WALL AFTER WALL: MENTAL HEALTH CARE FOR UNDOCUMENTED LATINA MIGRANTS

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Lastly, as a student of Tulane University, I acknowledge the position of extraordinary privilege from which I conducted this study. Throughout the research process, I attempted to use the utmost discretion in interpreting the profound statements made by both groups of participants. That being said, I urge everyone to examine the systems that allow some of us to achieve academic success while so many others are excluded from higher education. I encourage readers to sit with discomfort at what is lifted up throughout this thesis, to process the information, and to consider how you – in your personal or professional life – are contributing to and impacted by these harms, while also working towards a more equitable and healthy society for all.

ABSTRACT

Lydia Garrett-Metz. Wall After Wall: Mental Health Care for Undocumented Latina Migrants

(Dr. Eva Silvestre, Public Health)

This thesis studies access to and usage of behavioral health services by undocumented Latina migrants in the United States, while also analyzing current and former immigration and mental health care policy. There have been many investigations into the specific mental health conditions faced by this population, but I observed a dearth of study examining *why* and *how* existing behavioral health services struggle to provide for these women. Furthermore, many previously conducted studies discuss the issue of mental health care for the undocumented solely from the perspective of outsiders; in contrast, this thesis centers the perspectives and experiences of undocumented Latina migrants throughout. In order to do so, this study uses a cross-sectional qualitative research design that includes a literature and policy document review and key informant interviews with migrant women and service providers. This research allowed me to examine how U.S. systems fall far short of addressing the mental health needs of undocumented Latina migrants. I ultimately arrived at the conclusion that a complex matrix of socioeconomic, political, and cultural factors have led to the current status of this group as disenfranchised from adequate mental health care. I identify systemic, cultural, and organizational barriers to behavioral health care for undocumented Latina migrants including Latino beliefs about health, medicine, and healing/suffering; structures and views that subjugate non-citizen people of color into positions of poverty and social disadvantage; and the lack of Latino Spanish-speaking and culturally fluent providers in the U.S. mental health care system. These findings illustrate the multiple layers of this issue and lay the groundwork for future reform to address these stark disparities.

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LIST OF ABBREVIATIONS

ACA	Affordable Care Act
CDC	Centers for Disease Control and Prevention
CHIP	Children's Health Insurance Program
DACA	Deferred Action for Childhood Arrivals
DEI	Diversity, Equity, and Inclusion
DHS	Department of Homeland Security
DMV	Department of Motor Vehicles
ELL	English Language Learners
FQHC	Federally Qualified Health Center
GAD	Generalized Anxiety Disorder
GED	General Educational Development (Test)
ICE	Immigration and Customs Enforcement
IPV	Intimate Partner Violence
MDD	Major Depressive Disorder
MPP	Migration Protection Protocols
NIDA	National Institute on Drug Abuse
PTSD	Post Traumatic Stress Disorder
QoL	Quality of Life (Treatment-Driven Model)
SUD	Substance Use Disorder
TPS	Temporary Protected Status

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CHAPTER ONE: PREFACE

Give me your tired, your poor, your huddled masses yearning to breathe free, the wretched refuse of your teeming shores, send these, the homeless, tempest-tossed, to me; I lift my lamp beside the golden door. "The New Colossus," Emma Lazarus poem on the Statue of Liberty.

There is a crowded landscape of scholarship and debate about the undocumented population in the United States. This thesis focuses on a less studied segment of that population, Latina[1] migrants, and on the less examined problem of mental health care for these women. In doing so, this research questions conventional rhetoric, practice, and policy around the contentious issue of immigration and investigates how the current systems address – or fail to address – the mental health needs of undocumented Latina migrants. Ultimately, this thesis will point towards methods of improving care, culminating with a series of policy recommendations to increase access to comprehensive and culturally competent mental health care.

The field research for this study is based in the Greater New Orleans area and examines a population of undocumented Latina migrants and those who provide mental health care services to them. The Latino population in New Orleans has been steadily increasing over the last two decades, but a particular influx has been recorded since Hurricane Katrina, which devastated the city and led to an influx of migrants to work in construction and repair jobs (Vargas & Adelso, 2022). Furthermore, there are eight detention centers in the state of Louisiana, meaning that it is a location with

[1] I will use "Latina" to refer to the backgrounds of the undocumented migrant women in this study. Latino/Latina is used to refer to someone of Latin American origin (Central and South America, Mexico, and the Caribbean). While the terms Hispanic and Latino are oftentimes used interchangeably, Hispanic commonly refers to a person with ancestry from any Spanish-speaking country. As such, the study population will be referred to as undocumented Latina migrants in order to more closely represent their identities and countries of origin.

undocumented individuals at many different stages of the asylum process. In addition, a collaboration between the primary researcher and multiple social service agencies and community stakeholders that specialize in immigration work was already in place in New Orleans, making the city both a practical and an interesting field site for this research. Using this environment as a case study, this thesis will investigate the mental health care needs of this population, as well as *why* and *how* existing services struggle to provide for these women.

The principle research questions for this study are:

1. What are the behavioral health needs[2] of undocumented Latina migrants and why are these conditions or needs present?
2. What behavioral health services are available to undocumented Latina migrants in the Greater New Orleans area?
3. What are the perceived impediments to accessing care – from the perspectives of both the migrants and the providers?
4. What policy reform and advocacy work can be done to better the system and improve access for vulnerable individuals, specifically undocumented Latina migrants?

Mental illness is highly stigmatized in the United States, with the default outlook on these conditions often being one that blames the individual for what they are suffering from. As such, this thesis aims to re-center the narrative surrounding access to mental health care so that it is not one of victim-blaming. It seeks to increase understanding and

[2] For the purposes of this study, behavioral health needs are defined by the primary researcher as habits, behaviors, emotions, and events that affect overall well-being, specifically in regard to mental health and substance abuse.

scholarship about the relationship between the undocumented Latina community and the mental health care system, with specific focus on how and why disenfranchisement occurs. While substantial research exists about rates of depression, anxiety, and drug addiction within the migrant population, very little work deeply investigates the root causes of and potential solutions to this major health inequity (Beck et al., 2017; Garcini et al., 2018; González & González-Ramos, 2011; Hacker et al., 2015; Perez & Fortuna, 2013; see also Holliday-Moore & Chau, 2019; Sher & Vilens, 2011).

Many studies and debates around immigration focus on the harsh realities that motivate individuals and families to flee their countries of origin, the dangerous journeys to reach the U.S., and the legal, social, and political peril upon arrival. Politicians, the media, academia, and advocacy all continue to wrestle over the multitude of challenges related to the undocumented population and their many competing interests and complexities. But as this paper will illustrate, nowhere are the challenges more fundamental, more urgent, or more potentially impactful on the lives of this community than in accessing health care. And here, playing out in the shadows of the broader American healthcare system is the complex and often overlooked problem of mental health care.

This is a multi-dimensional issue, with institutional barriers and cultural impediments for those needing care, as well as those in a position to provide care. The American behavioral health care system is overall notoriously underfunded, its importance underappreciated, and its missions often stigmatized. These underlying issues exacerbate the challenges for a particularly vulnerable and needy segment of the population without the resources to access the system, as limited and imperfect as it may

be. It is, in a multitude of ways, a perfect storm of misery: the trauma of migration, the high hurdles of American society, social isolation fueled by the lack of legal status, financial security, and language barriers – to name just a few of the many factors at play. Though not often in the spotlight, perhaps unsurprisingly, mental illness is both astonishingly present and very rarely treated in undocumented communities.

To examine these issues, this thesis proceeds as follows. Chapter Two establishes a starting point for the research by providing an overview of the issue of mental healthcare for undocumented Latina migrants and tracing the early history of immigration policy and restrictions in the United States. Chapter Three reviews the existing literature related to mental health and mental healthcare for undocumented Latina migrants; it also identifies areas of agreement and contradiction within the literature. Chapter Four outlines the methods used to conduct this study and lays out the research questions. In this chapter, I explain the use of a cross-sectional qualitative research design which includes a literature and policy document review and key informant interviews with migrant women and service providers. Chapter Five reports the results of the key informant interviews and analyzes them thematically based on criteria established by the study's research questions. In Chapter Six, I provide a thorough analysis of my findings from Chapter Five in comparison to the data collected from the literature review. This chapter also identifies the implications of what was shared by study participants. Chapter Seven revisits the study's research questions, briefly summarizes the overall findings of the thesis, and provides recommendations for future research and policy reform.

Considering the continued growth of the undocumented population and stresses of poverty and marginalization from the mental health care system, this research will offer

unique insights and proposals that contribute to a greater understanding of the issues and the urgency for change. Addressing the unmet needs of undocumented Latina migrants is an imperative for public health reasons; it is also a test of whether we can live up to the American ideal as a beacon for the “tempest tossed,” whether we will lift the “lamp beside the golden door.”

CHAPTER TWO: BACKGROUND

For the purposes of this paper, an undocumented individual in the U.S. is defined as someone who may "lack appropriate documents regarding citizenship, have overstayed a visa, or otherwise have violated terms of their residency (Passel & Cohn, 2011). It is important to acknowledge that this description is not universal; different terminology referencing this population is used throughout existing research. Kroening and Dawson-Hahn (2019) provide a series of definitions of migration status, swapping out the term "undocumented" in favor of "newly arrived" migrants (p. 88). They define immigrants as "individuals who have left their country of birth to establish residency in a new country," though this paper uses the term "migrants" to refer to this same circumstance (Kroening & Dawson-Hahn, 2019, p. 89). Similarly, a 2005 report from the Pew Research Center uses the term "unauthorized migrant" rather than "undocumented migrant" when referring to a person who "resides in the United States, but who is not a U.S. citizen, has not been admitted for permanent residence, and is not in a set of specific authorized temporary statuses permitting longer-term residence and work" (Passel, p. 2). These examples of the varying terminology used by researchers provide a glance into the diversity of the field and the information within it; they also point towards potential limitations of the research, as it was not possible to access materials that used every possible migration-related term.

As such, there is a fundamental contradiction between the United States' founding narrative as a "nation of immigrants" and the way that immigrants are cared for in this country. The contradiction is especially stark when considering not just the ideological history of the country, but the sheer numbers: noncitizens make up 7% of the U.S.

population, or 22.1 million people (*Health Coverage of Immigrants*, 2022). Among this group, over 12 million people are commonly described as undocumented: being "foreign-born" and "residing in the United States without authorization," of which the majority identifies as Hispanic/Latino (*Health Coverage of Immigrants*, 2022).

But just as the idea of immigration is enshrined in our country and inscribed on the Statue of Liberty with the words, "Give me your tired, your poor, your huddled masses," so is harsh immigration policy. It starts with the very founding of the United States. American immigration policy can be traced back to the 17th and 18th centuries, when the colonies were adjusting to the rapid influx of new arrivals. D'Vera Cohn explains that within just three years of gaining independence, the government passed the 1790 Naturalization Act, which limited citizenship in the United States to "free white person(s)" of "good moral character" who had resided in the country for at least two years (2015). The American people felt that the residency requirement of two years was not long enough, and between 1790 and 1802, it was extended to five years, then 14, then back to five (Cohn, 2015). Historian Patrick Ettinger states that as the Naturalization Act began to define the terms of citizenship, the Continental Congress officially placed limits on immigration with the Alien and Sedition Acts of 1798 (2009). This allowed the president to deport any person that was deemed to be committing acts of treason or otherwise posing a threat to the safety of the United States (Ettinger, 2009, p. 16). In practice, this closed the door on a far wider group of people, preventing them from entering the country.

The U.S.-Mexican border became a point of contention in the late 1800s, when El Paso, Texas, received congressional approval for an international bridge that would span

the Rio Grande in an effort to promote Mexican trade (Ettinger, 2009, p. 13). Ettinger underscored that:

> The vibrancy of El Paso testified to the dynamic possibilities of the emerging transnational economic ties, but the very same rail lines providing 'intimacy of traffic' between the nations [had]...profound implications for patterns of immigration to the United States in the coming decades (2009, p. 14).

These implications were immediate and harsh: the Immigration Act of 1875 prohibited the migration of criminals and made it a federal crime for an Asian laborer to enter the country, as well as for contracting an Asian laborer to come to America (Cohn, 2015). This had wider implications than just barring criminals: the act was the nation's first legally restrictive immigration statute, and set much of the precedent that we see throughout the next 150 years in terms of immigration policy (Cohn, 2015).

By December of 1891, Chinese natives, who were not allowed in the U.S. under another restrictive immigration policy – the 1882 Chinese Exclusion Act – were smuggled across the border via these new transportation lines. During this time, "criminals, people with contagious diseases, polygamists, anarchists, beggars, and importers of prostitutes" were also forbidden from entering the country, regardless of race or origin (Cohn, 2015). Those restrictions had the effect of keeping even ordinary people out. Ettinger observes that "even as the United States was building bridges across the Mexican border in the 1800s, it was also beginning to fashion walls" (2009, p. 14).

It was at this point in American history that the border, and those who moved themselves across it, were clearly defined as threats to society. They were no longer people, but "carriers of disease and moral disorder, culturally unassimilable others, threats to the political order and social stability, and [sources of] unfree labor" (Ettinger, 2009, p. 15). More than 200 years later, many of these attitudes persist, informing the

national viewpoint on immigration. The devastating effects of this perspective reverberates through generations.

CHAPTER THREE: LITERATURE AND POLICY REVIEW

Literature Review Methods

The literature review establishes the fundamental problems and challenges faced by undocumented Latina migrants, as well as by healthcare providers. It investigates methodologies and clinical practices currently used and generates answers to the key research questions. The literature was thoroughly compared against data obtained from the provider and migrant interviews. The policy document review examines publicly accessible manuals, protocols, and statements, as well as laws and regulations that are pertinent to the study population, in order to analyze the current approaches to mental health care, intentions, shortcomings and successes.

An initial search for the literature review included the keywords: *immigrants - undocumented, illegal; injectable, drug use, heroin, war on drugs, immigration policy, mental health, access to mental health care, behavioral health(care), Latino/Latina, depression, suicide, substance abuse, abuse, violence, domestic violence, battered women, IPV, machismo, marianismo.* Literature was mainly collected using Tulane University's Howard Tilton Memorial Library database as well as other scholarly search engines such as PubMed, SAGE, ERIC on EBSCOhost, and Google Scholar. Preliminary searches produced hundreds of seemingly relevant articles based on their titles; analyzing the abstract of each of these works helped to exclude those that were not truly relevant to the study population and the issues facing them. In the final stages of the literature review, article's bibliographies were reviewed to identify any additional works of relevance that were not acquired in the database searches.

Main themes identified in the literature review were divided into two categories for the clarity of the thesis: (1) mental health care and (2) immigration. While these two categories clearly overlap, organizing the themes in this way helped to conceptualize preliminary findings from two different policy perspectives (health care policy vs. migration policy). First, I review the mental health care related themes from the literature, including (1) holes in the healthcare safety net; (2) the debate over healthcare for undocumented Latina migrants; (3) lack of trust in the U.S. healthcare system; (4) incidence, prevalence, and conceptualizations of various mental health disorders among this population; and lastly (5) determinants of mental illness for undocumented Latina migrants. Determinants identified include the migration experience, traditional Latino gender roles and Latina femininity, and the stigmatization of mental illness in Latino culture, and disparities in provision of and access to mental health care. Figure 1 illustrates these main themes in the mental health care category produced from the literature review.

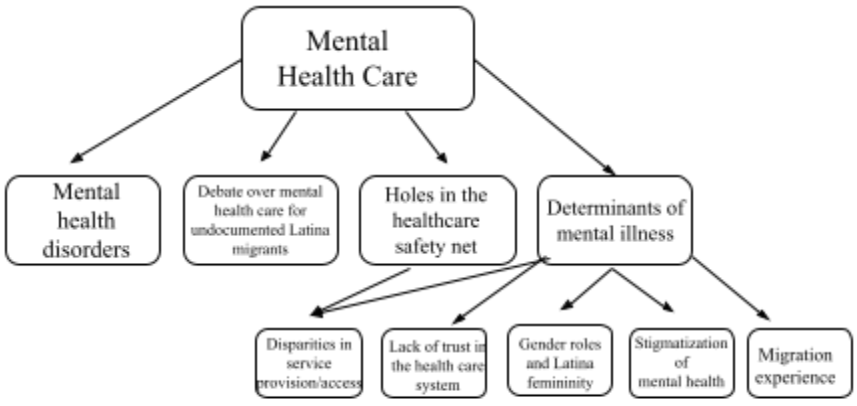

Figure 1. *Mental Healthcare Policy Themes*

Next, I review the immigration related themes from the literature, including (1) immigration policy of the 1900s; (2) the presidencies of Clinton, Obama, Bush, Trump, and Biden; (3) policy implications for migrants, (4) impediments to accessing care, and (5) current policy. Impediments to care identified include socioeconomic status, Latino culture, and lack of information and/or knowledge. Figure 2 illustrates these main themes in the immigration policy category produced from the literature.

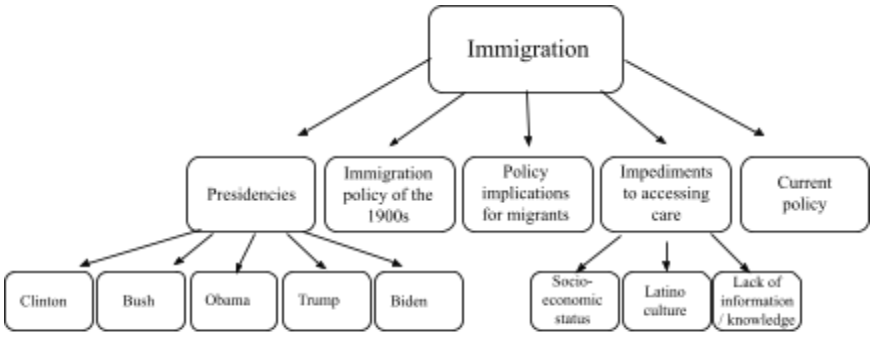

Figure 2. *Immigration Policy Themes*

The third portion of this chapter synthesizes the more specific data pulled from the previous two sections. This final section describes what the literature identifies as the current state of the issue, based on policy and research. It highlights impediments to accessing and receiving mental healthcare for undocumented Latina migrants, analyzes existing mental healthcare and migration programs, and identifies gaps in the literature that this thesis aims to address.

Part One: Mental Healthcare Policy

Holes in the Healthcare Safety Net

Despite being one of the richest countries in the world, with a high standard of medical care, millions of people in the U.S. are without health insurance or the means to

obtain it. For them, health care typically comes through a "safety net" system of public and teaching hospitals with emergency rooms, community-based clinics, urgent care facilities, and local health departments (Lewin & Altman, 2000, p. 17). One study noted that 1.5% of total U.S. medical costs can be attributed to undocumented migrants, and that the majority of these costs are incurred from hospital emergency room visits (Edward, 2014, p. 7). These public "safety net" hospitals are legally required to treat every person who visits the emergency room regardless of their ability to pay, health insurance coverage, or immigration status, meaning that the institutions are often left with unpaid medical bills from the emergency department, ultimately increasing overall healthcare costs and expenditures (Edward, 2014, p. 7).

For the undocumented, a crucial component of this system is a national network of healthcare clinics known as Federally Qualified Health Centers. FQHCs have been touted as a valuable resource for this population in regard to accessing care; they provide an array of services – including mental health care – on a sliding payment scale, meaning that they are generally accessible to the uninsured (Beck et al., 2017, p. 35). The National Association of Community Health Centers (2022) reports that Federally Qualified Health Centers serve 1 in 17 uninsured people across the United States, 1 in 5 of which are uninsured and low-income (a category into which many undocumented migrants fall). The low number of insured patients seen in FQHCs (and other safety net providers) means that they cannot shift costs for care onto private insurance companies and therefore must rely largely on funding from federal, state, and local grants to subsidize care (Lewin & Altman, 2000, p. 49). Research by Beck et al., shows that there are around 1,400 of these health centers in the United States; despite receiving federal funding,

FQHCs are required to provide care to clients without regard for demographic information like immigration status – though this care is not guaranteed to be holistic, comprehensive, or culturally-competent (2017, p. 35).

Scholars and those on the ground seem to agree that the healthcare safety net is notoriously-ill equipped to handle even standard health care, let alone try to address the mental health needs of the undocumented population (Lewin & Altman, 2000, p. 2). Medical centers within the system often have low standards of care, inaccessible services, and in the worst case scenarios, incompetent providers. Lewin and Altman (2000) describe the system as "a patchwork of providers, funding, and programs tenuously held together by the power of demonstrated need, community support, and political acumen," that is currently facing unprecedented levels of risk due to rising rates of uninsurance (p. 17). Furthermore, data shows that Latinos, regardless of immigration status, are more likely to utilize the general medical services found in the safety net to address their mental health needs rather than specialized mental health professionals (Cabassa et al., 2008, p. 6; Lewin & Altman, 2000). Not only does this reduce primary care doctors' capacity and availability to treat their normal client base, it also means that patients who seek mental health care from these doctors may not be receiving specialized and comprehensive approaches to their unique situations.

The Debate: Healthcare for Undocumented Migrants

One author explains that because overall healthcare costs can be reduced when more people pay into the healthcare system, barring undocumented immigrants from purchasing health insurance is financially detrimental to others who pay into the system (Edward, 2014, p. 8). In contrast to this argument, there is still wide opposition to the

provision of health care services for undocumented migrants. Beck et al., say that those who oppose providing free healthcare to undocumented immigrants often argue that using American tax-dollars to support individuals who are not authorized to be in the country undermines the U.S. legal system while saving the migrant's origin country from bearing the cost of their healthcare (2017, p. 38). In addition, those in opposition maintain that providing healthcare resources to undocumented migrants takes away these resources from legal citizens (Beck et al., 2017, p. 38). Indeed, when it comes to mental health care for the undocumented in the United States – from psychiatric services to substance abuse treatment to behavioral therapies – it is a harrowing experience of facing wall after wall.

Fleeting Faith in the Provision of Healthcare Services

The overarching theme of trust emerges in the discussion of what should or could be done to facilitate mental health care access and promote system interaction in the undocumented Latina population. Because many members of the undocumented community rely solely on the healthcare safety net, they must be able to trust those systems that often provide the only care that they are able to receive. Yu et al., cite fear and skepticism as factors that are displacing and eroding patient trust in the healthcare system, which puts the efficacy and utilization of healthcare at great risk (2020, p. 372).

Undocumented Latina migrants' lack of trust in the U.S. healthcare system directly impacts both the individual and their family structure. Because women are often normatively designated as the caretaker of the family in Latino culture, when they lose trust in the healthcare system it has a ripple effect, from their own families and throughout the community. Undocumented Latina migrants interviewed in one study reported that they typically seek out medical care only in emergency situations, and that

that care was primarily for the health of their children or grandchildren, not themselves (Moya & Shedlin, 2008, p. 1755). Hacker et al., explain the devastating impacts of this dynamic on the health of the family: undocumented migrant women in their study avoided seeking care for their children who *were* legally authorized to be in the U.S. because they feared having to provide documentation for themselves upon arrival (2015, p. 8).

Mental Health Disorders Among the Undocumented

The undocumented Latino community is generally hesitant to seek out healthcare resources and treatment or to interact with healthcare systems at all due to fear of deportation, family separation, and other migration-related traumas. This innate distrust of government-affiliated organizations and healthcare institutions is further exacerbated by fears of deportation and separation and is particularly common in Latino families with mixed documentation statuses (Chau, 2020, p. 12).

These fears are often accompanied by a high prevalence of mental health conditions such as anxiety, depression, PTSD, and suicidal ideation among Latino migrants (Chau, 2020, p. 5). One study found high rates of major depressive disorder, borderline personality disorder, psychosis, substance abuse disorder, generalized anxiety disorder, bipolar disorder, and suicidal ideation among undocumented Latino participants (Perez & Fortuna, 2005, p. 116). Compared to mental health diagnoses among U.S.-born Latinos, the undocumented group had greater likelihood of being diagnosed with depression, anxiety, adjustment, and alcohol abuse disorder (Perez & Fortuna, 2005, p. 117). In addition, this group also presented more concurrent psychological stressors and

issues in regard to acculturation, health care, the legal system, and occupation status than their documented counterparts (Garcini et al., 2017; Perez & Fortuna, 2005, p. 108).

Poor mental health is often a precursor for substance abuse, especially of alcohol and opiates. According to the National Institute on Drug Abuse, 43% of U.S. adults across all racial/ethnic and socioeconomic demographics who suffer from substance abuse disorders also had other mental illnesses, particularly depression and anxiety (NIDA, 2021, p. 3). More than 10 percent – or 1,340,000 – of Latino adults in the United States had a co-occurring SUD and other mental illness in the past year, with pre-existing disorders such as depression or anxiety increasing the potential for abuse of an opioid in the future (Chau, 2020, p. 11). There has been an increase in opioid misuse and death among Hispanic/Latino populations in recent years, with 1.7 million Latinos aged 12 and older reporting misuse of opioids in 2018 (Chau, 2020, p. 5).

Additionally, Latinos in the United States are often victims of discrimination, a well documented risk factor of poor mental health outcomes (Cobb et al., 2017; Garcini et al., 2018). Undocumented immigrants are constantly victimized by interpersonal discrimination; one body of research found that of its study population of undocumented Latino individuals, 69% indicated that they had been discriminated against. Female participants are more likely to report extreme stress as a result of interpersonal discrimination for being undocumented in comparison to male participants (Garcini et al., 2018, p. 11). Furthermore, many migrant families end up settling in communities plagued by high poverty rates and characterized by economic disinvestment, which have much higher rates of intergenerational- and poly-substance use than more affluent areas do (Chau, 2020, p. 6).

One study cited by Beck et al., compared diagnoses of undocumented Latinos to documented Latinos and US-born Latinos, showing that the undocumented group had higher rates of anxiety, adjustment, and alcohol abuse disorders (2017, p. 8). The study also reported increasing rates of substance abuse, mood disorders, and eating disorders like binge-eating among undocumented Latino migrants in correlation to the length of time they were in the United States (Beck et al., 2017, p. 8). Substance abuse emerged throughout literature as one of the main issues impacting the mental health of the undocumented Latino population; the "drug of choice" for migrants during their first three years post-migration to the U.S. is reported to be alcohol (Moya & Shedlin, 2008, p. 1756). This study concluded that because drugs are increasing in availability and accessibility on both sides of the U.S.-Mexico border, consumption of substances like alcohol, marijuana, heroin, cocaine, crack, and methamphetamines have increased as well (Moya & Shedlin, 2008, p. 1756). While some of these substances are more dangerous than others, women enrolled in this study revealed that their average age of drug use initiation was 18 to 29 years, meaning that many Latina migrants have likely been using substances since their teenage years (Moya & Shedlin, 2008, p. 1756).

Determinants of Mental Health Outcomes

Migration as a Determinant. The migration experience was cited by Ornelas and Perrerira (2011) as a determinant of major depressive disorder among Latino migrants. Among their sample of undocumented Latino migrants, Ornelas and Perrerira found that almost all of the participants feared for their life or their safety during migration; half identified migration as causing them significant stress; and 13% reported a traumatic event during migration such as a violent attack or robbery (2011, p. 1176).

Post-migration, one-third of the participants reported that they experienced racial/ethnic discrimination that greatly increased their stress levels – which can consequently be assumed to have deteriorated their overall mental health (Ornelas & Perreira, 2011, p. 1177).

The Impact of Gender Roles. A determinant of mental illness among females in particular was found to be their interpersonal relationship with a romantic partner (current or former). Moya and Shedlin specifically cite "weakened relationships, separations, domestic violence, [and] the influential role that males play in women's initiation and persistent [substance] use" as extremely impactful factors on the drug use of undocumented Latina migrants (2008, p. 1756). Among some segments of Latino culture, women continue to be relegated to a position that hinders their ability to recognize and/or choose to address their mental health struggles, defined by the Latino cultural norms of men as strong and dominant (*machismo*) and women as submissive and delicate (*marianismo*) (Nuñez et al., 2016). *Marianismo,* which subjugates women to submissive caretakers and homemakers, can potentially stoke a migrant woman's heightened sense of responsibility as well as their fear about not being able to fill that role (Nuñez et al., 2016).

Studies have linked the normative attitudes and behaviors of *marianismo* with high levels of negative emotional functionality and worsening cognitive outcomes among women (Nuñez et al., 2016, p. 9). As noted, *marianismo* defines women as being centered around their families and homes, while also encouraging passivity and self-sacrifice with respect to patriarchal values (Nuñez et al., 2016, p. 3). Adherence to this gender role leads to less overall psychological well-being; specifically, high rates of

depressive symptoms and low self-worth due to the normative expectations for women within Latino culture. Women are deemed responsible for the well-being and spiritual growth of their families, and are also identified as the strengthening pillar of the family, which can cause severe emotional burden (Nuñez et al., 2016, p. 10). Because of the emphasis that *marianismo* places on submission to the patriarchy, many Latina women silence themselves and suppress their emotions to maintain this power structure. This ultimately decreases their likelihood of seeking support for any mental illness they may be suffering from (Nuñez et al., 2016, p. 10).

Stigma and Mental Health. Women also identified stigma and marginalization as important influences on their drug use, saying that because addiction is stigmatized by their communities and families, they are more hesitant to seek treatment. This powerful cultural stigma stems from a generalized perception that addiction is a "moral failing" rather than a disease. Because of this stigma, many Latino individuals with a substance use disorder (SUD) refrain from seeking treatment. Some note a familial lack of understanding about addiction or having seen a family member relapse repeatedly, thus leading them to believe that recovery is not possible (Chau, 2020, p. 7). Internalization of this stigma can lead to the mentality that treatment is either not needed or is pointless, because recovery is impossible, or that only God is capable of aiding their struggles. These ideologies help to explain why only 5% of individuals of undocumented Latino migrants who are suffering from SUD seek treatment (Chau, 2020, p. 7). One study found that women who had been to treatment for substance use disorder said that a court mandate was the main reason why they had gone, because it otherwise would have been

too expensive and they were too ashamed of their disease (Moya & Shedlin, 2008, p. 1757-1758).

In an interesting finding by Cabassa et al., men of Latino origin were more likely to *receive* care for a perceived mental health issue than their female counterparts (2008, pg. 8). It is important to note females are more likely to *seek* mental healthcare services than males (Fortuna et al., 2008, p. 436; Garcini et al., 2018, p. 11). One analysis of this dichotomy by Moya and Shedlin suggests that this may be due to the role of many undocumented Latina migrants as the primary caregiver of their children, and the fear that seeking treatment or visiting a healthcare facility could result in deportation, family separation, or intervention by Child Protection Services (2008, p. 1757).

Latina Femininity and Mental Health. As one of the most vulnerable groups within the Latino undocumented community, women are disproportionately affected by both mental illness and barriers to treatment. The unstable positionality of many Latina migrants without legal documentation is a driving factor in their high prevalence of mental illness, which the available data suggests is at a greater rate than in the general U.S. population.

One study assessing mental illness among a sample of majority females who crossed the Mexico-U.S. border and had lived without legal documentation in the United States for an average of 10 years, affirms this notion (Garcini et al., 2017, p. 18). The study population reported notably higher rates of Major Depressive Disorder (MDD) and Generalized Anxiety Disorder (GAD), specifically panic disorder, in comparison to the general population of the United States (Garcini et al., 2017, p. 16). Additional data shows higher lifetime prevalence of dysthymia, panic disorder, and a wide range of

phobias in Mexican-American women than in all other groups (Perez & Fortuna, 2005, p. 111). Though female Mexican migrants only represent a small subset of the generalized Latina population, the data provided by Garcini et al., provides an indication that undocumented Latinas may be disproportionately affected by mental illness.

Care Disparities From the Migrant Perspective

When asked about what mental healthcare options were available to them, most of the respondents in a study by Moya and Shedlin said that they were unsure; they reported not knowing how being undocumented affected their rights and ability to access treatment for mental illness and substance abuse (2008, p. 1758). In this same study, participants expressed the "need for numerous treatment and auxiliary services…including family and marital counseling; classes on immigration (how to apply for citizenship, legal aid assistance); employment skills; and referrals to health services (anger management, diabetes and hypertension care)" (Moya & Shedlin, 2008, p. 1758). Individuals also noted the lack of affordable and accessible treatment options for what Moya and Shedlin call the "functional drug addict," – one who is able to perform their daily responsibilities and participate appropriately in family engagements (2008, p. 1756). Despite the lack of knowledge and adequate dissemination of information to the undocumented Latina population, services to provide for them do exist – but they lack the necessary comprehensive, culturally appropriate, and holistic care mechanisms.

Political Parameters of Mental Health Care for the Undocumented Population

Even when the desire to seek help for a mental health concern exists, accessing care – specifically care featuring quality services and culturally competent providers – without legal status and financial resources is extremely difficult. Thus, it is impossible to

contemplate the mental health care challenges for the undocumented population without examining the political and policy environment that surrounds them.

It starts with the bedrock reality that immigration is currently among the most polarizing issues in American society. As a country, we continue to fight over who "belongs" in America, what rights and services are afforded to those here without legal status, and what the impacts are of immigrants on the economy, the political sphere, and even day-to-day life. The issue of "belonging" is a key barrier to accessing mental health care for undocumented migrants: they are not eligible for Medicaid or state-based health insurance and are not provided any benefits under the Affordable Care Act, which mandates most citizens and legal residents of the U.S. to have health insurance (Beck et al., 2017).

Results from a study by Yu et al., illustrate the realities of this policy: undocumented migrants are excluded from free or reduced-cost health care provisions in many places because they cannot purchase health insurance in the ACA marketplace (2020, p. 367). They are also not eligible to enroll in Children's Health Insurance Program (CHIP), which provides insurance to children from families whose parents earn too much money to qualify them for Medicaid, further disenfranchising the entire family from essential health care services (Yu et al., 2020).

Beck et al., explains that the only exception is for emergency care in unprecedented circumstances: the Emergency Medical Treatment and Labor Act of 1986 stipulates that Medicaid must cover preliminary care for undocumented individuals either in active labor or suffering from an acute medical need (2017, p. 35). Once the patient is stabilized, Medicaid does not cover any additional services. As a result, most

undocumented migrants do not have health insurance and thus solely rely on the safety-net health system, evident through the high rates of emergency room and urgent care visits observed in undocumented populations (Yu, et al., 2020, p. 371).

In this context, policies and practices impacting mental health care for the undocumented have become increasingly restrictive and limited in recent years – notably during the Trump era under the overarching Zero Tolerance ideology. In the absence of supportive federal policies, access to and the effectiveness of mental health care services now often depend on local and state governments, as well as non-governmental organizations (Yu, et al., 2020, p. 367). It can be best described as a "patchwork approach" (Lewin & Altman, 2000, p. 4).

Policies like the Public Charge Rule, a Trump-era decision (now overturned) that identified receiving or expecting public benefits like Medicaid and food or housing assistance as grounds for denial of permanent resident status, only exacerbated health care inconsistencies. In the wake of this policy, studies reported dramatic increases in fear and hesitation among undocumented individuals in accessing services of all kinds, including health care (Yu et al., 2020, p. 367). As previously noted, many undocumented communities rely on acute care for all of their health-related needs, meaning that urgent care clinics and emergency rooms typically provide the majority of services to these groups. Thus, in the aftermath of the Public Charge Rule, utilization of primary care clinics that typically served this population sharply dropped as immigrant families lost trust in the health care system (Yu et al., 2020, p. 370). Even in California, a state with some of the most comprehensive immigrant-care policies, many undocumented Latinos

disenrolled themselves from state-sponsored public programs like Medi-Cal and My Health LA as their trust in U.S. health care services declined (Yu et al., 2020, p. 370).

In contrast to the negative and fearful ideas held by many members of the undocumented community about clinics, Yu et al., interviewed service providers, or those who work in these facilities, and learned that they typically perceive their primary care clinics as "safe spaces" for this population (2020, p. 368). This contradiction between perceptions perpetuates the divide between those in need of services and those who are in a position to provide them.

Part Two: Immigration Policy

Immigration Policy of the 1900s

In the 1900s, fuel was thrown on the anti-immigration fire as Irish migrants fleeing famine arrived in New York, Canada, and Mexico in the millions. These locations were identified as "hot spots" for illegal border-crossing, and the Immigration Act of 1903 was passed stating that "those likely to become public charges" were barred from the United States (Ettinger, 2009, p. 70). This same legislation restricted anarchists, beggars, and importers of prostitutes from immigrating to America (Cohn, 2015).

Throughout the 1900s, race was clearly defined as a criteria for the deportation or exclusion of a migrant from America, and still informs the racist immigration narratives that dominate the debate today. In 1952, the Immigration and Nationality Act formally removed race as a criterion for exclusion from immigration and naturalization - although it maintained that mental illness, and political activities and ideologies, were valid basises for barring someone from the U.S. (Cohn, 2015).

In the 1980s, civil wars in El Salvador, Guatemala, and Nicaragua induced large numbers of Central Americans to migrate to the United States (O'Connor et al., 2019). In response, the U.S. continued to impose stricter limits on entering the country – and with these limits came a plethora of negative stereotypes and racist ideologies about virtually anyone who was not a white, American-born, U.S. citizen. Cohn's research notes that mass deportations began to occur at unprecedented rates, although the Reagan and Bush administrations of the late 1900s did attempt to spare the minor children and spouses/unmarried partners of undocumented migrants from deportation (2015). The 1986 Immigration Reform and Control Act created a pathway to legal permanent residency for people who had been in the U.S. since 1982 and had been working in certain agricultural jobs during this time (Cohn, 2015; O'Connor et al., 2019). The Act also instituted sanctions for employers who hire undocumented workers and further increased enforcement at the Southern border (Cohn, 2015).

In the wake of the Immigration Reform and Control Act, the Reagan administration and the George H.W. Bush administration took action related to family separation. Under Reagan, minor children of parents who were legalized under the Act could no longer be deported; under Bush, all spouses and unmarried children of those legalized under the Act could apply for citizenship and a work permit (Cohn, 2015). These policies were formalized in the Immigration Act of 1990, signed into law by President Bush, and introduced "Temporary Protected Status" (TPS), which is a policy that is still in place today. TPS stipulates that undocumented individuals in the United States who are experiencing extraordinary conflict in their country of origin are temporarily protected from deportation (Cohn, 2015). It is important to note that

individuals from only 14 countries are eligible for TPS consideration, including Honduras, Nicaragua, and El Salvador; and around 400,000 foreign nationals are granted this status every year (O'Connor et al., 2019; *Temporary Protected Status*, 2021).

Clinton Presidency and Immigration Reform

In 1996, President Clinton signed the Illegal Immigration Reform and Immigrant Responsibility Act, which seems to directly mirror a later enacted Trump-era immigration policy. This Act called for increased enforcement at the Southwest border, mandated the building of fences at border "hot spots," and cracked down on anyone who *could* be "deportable" in the U.S. (Cohn, 2015; Moya & Shedlin, 2008, p. 1759). These rigid practices were ostensibly designed to protect and secure America and deal with the many real issues that immigration poses, but as illustrated by analysis from O'Connor and colleagues, they may have ultimately done more harm than good (2019). Not only has the Illegal Immigration Reform and Immigrant Responsibility Act created a tiered, unequal society and caused divisiveness in the country, but it fails to address the underlying problem: that many of these migrants are fleeing insecurity and poverty exacerbated by drought and crop failure while simultaneously facing gang activity, extortion, especially high homicide rates, and corrupt public institutions (O'Connor et al., 2019).

The Bush and Obama Presidencies

President George W. Bush took a dichotomous and at times contradictory approach to immigration – one that Edwards and Herder describe as both inclusionary and exclusionary – as he depicted immigrants as productive and important but also as "others" who strain American government and resources while living in the "shadows of society" (2012, p. 41).

In the aftermath of the 9/11 terrorist attacks, calls to strengthen policies that restrict entrance to the United States began to increase. Under Bush, the Department of Homeland Security (DHS) – the governmental organization that contains the U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, and U.S. Citizenship and Immigration Services – was created with the passage of the Homeland Security Act (Cohn, 2015). DHS effectively took the place of the U.S. Immigration and Naturalization Service and initiated stark crackdowns on migration into the United States (Cohn, 2015). These government agencies, particularly Immigration and Customs Enforcement and Customs and Border Protection, are now notorious for their harsh, often violent tactics aimed at barring unauthorized immigration into the United States.

When President Obama took office in 2008, he spoke of a different approach to immigration, highlighting what he believed was the impossibility of removing the reported 11 million undocumented immigrants from the country. Instead, the Obama administration chose to focus on recent unauthorized entries, and direct threats to public safety and national security (Law Enforcement Immigration Task Force, 2021, p. 1). In 2012, Obama issued an Executive Order that created Deferred Action for Childhood Arrivals (DACA), a program which allows undocumented young adults between 15 and 30 years old who came to the U.S. as children to apply for temporary deportation relief and a two-year work permit (Cohn, 2015).

Trump Presidency

Former President Trump was elected, in part, for his hard stance against immigration. Immediately upon taking office, he prioritized the removal of any and all undocumented immigrants (Law Enforcement Immigration Task Force, 2021, p. 3). He

kicked off his 2016 campaign announcement with the incendiary, “when Mexico sends its people, they’re not sending their best...They’re sending people that have lots of problems, and they’re bringing those problems to us. They’re bringing drugs. They’re bringing crime. They’re rapists. And some, I assume, are good people'" (Trump, 2015). His speech caused an immediate explosion of both outrage and approval as Americans began to define themselves as either for or against Trump’s hyperbole. This inflammatory rhetoric soon became policy. In an effort to deter immigration and sow fear, his administration began the extraordinary practice of separating children from their parents at the border and expediting the deportation process with policies like Title 42 and Remain in Mexico.

Title 42 is named for a section of the U.S. Code that “empowers federal health authorities to prohibit migrants from entering the country if it is determined that doing so could prevent the spread of contagious diseases,” and was invoked by the CDC in March of 2020, during the height of the global COVID-19 pandemic (Gramlich, 2022). The Trump administration stated that use of Title 42 would help prevent the spread of COVID-19 in the crowded border detention facilities by reducing the number of people crossing the border (Gramlich, 2022; Hackman, 2023). Between April 2020 and March 2022, the U.S. Border Patrol has reported around 2.9 million encounters with migrants along the U.S.-Mexico border, with nearly 1.8 million of those encounters resulting in the deportation of the individual under Title 42 (Gramlich, 2022).

Remain in Mexico, or Migration Protection Protocols (MPP), began on January 25, 2019 under President Trump and Mexican President Andrés Manuel López Obrador (*'Remain in Mexico': Overview and Resources*, 2022). The policy mandates that U.S. Border Patrol officials must return asylum seekers to Mexico while they wait for their

asylum claims to be adjudicated in U.S. Immigration Court. Between January 2019 and January 2021, 71,000 asylum seekers were sent to Mexico, tens of thousands of which were children (*'Remain in Mexico': Overview and Resources*, 2022).

Biden Presidency

The current Biden/Harris administration has approached immigration policy in a way similar to the earlier Obama administration, prioritizing the deportation of undocumented migrants identified as posing threats to national security and public safety, as well as recent illegal entrants (Law Enforcement Immigration Task Force, 2021, p. 4).

While President Biden has attempted to end both Title 42 and Remain in Mexico, these Trump-era policies are currently still in effect – with some adjustments (Hackman, 2023; *'Remain in Mexico': Overview and Resources*, 2022). Writing for *The Wall Street Journal*, Hackman explains that the Biden administration intended to fully end use of Title 42 by May 2022, but a federal judge in Louisiana prevented its termination on the grounds that the correct administrative procedure had not been followed in doing so (Hackman, 2023). That being said, the use of Title 42 for unaccompanied minors was ended in March 2022; the CDC states that with their guidance, the Office of Refugee Resettlement is responsible for caring for these children after they are encountered, and can only release them from government custody after COVID-19 testing and vaccination (Centers for Disease Control and Prevention, 2022). Both Trump and Biden have claimed that Title 42 is a public health emergency law, not an immigration law; critics, however, say these two things cannot be untangled from one another, meaning that Title 42 is an immigration management tool by virtue of its existence (Hackman, 2023).

President Biden initially rolled back Remain in Mexico in June 2021, calling it "dangerous" and "inhumane," but in December 2021 the administration began an "improved" version of the program (*'Remain in Mexico': Overview and Resources*, 2022). Under the policy's second iteration, most asylum cases must be solved within six months, asylum seekers will be given access to counsel, and "particularly vulnerable individuals" will be excluded from the policy's target population (*'Remain in Mexico': Overview and Resources*, 2022). The Human Rights Watch has spoken out against this decision, claiming that these "improvements" are baseless promises that are not being kept by either the United States or Mexico (2022).

Policy Implications for Immigrants

A study conducted by Moya and Shedlin (2008), which interviewed 30 undocumented migrants of Mexican origin, revealed that there was a genuine lack of knowledge among participants about laws and policies that affected their legal status or rights in the United States post-migration (p. 1759-1763). Their research explains that this confusion and ambiguity among the study sample about immigration policy is likely to only further the divide between citizens and noncitizens, enhance anti-immigrant rhetoric, and maintain the current exclusionary culture in the United States (2008, p. 1763).

As evident through the review of how presidential administrations have addressed immigration, it is clear that the issue is controversial, contentious, and extraordinarily important. Every president since Eisenhower has used their platform to take executive action on immigration, illustrating that the instability of the current migration system is persistent throughout time and changing political climates (Wolgin, 2014).

Part Three: Current State of the Issue

Impediments to Accessing Care

Low socioeconomic status, decreased language proficiency, fear of deportation, lack of availability of or high out-of-pocket costs for federal insurance plans, and work constraints are all cited by Beck et al., as barriers to care for the undocumented Latino population (2017, p. 34). These factors are corroborated by Hacker et al., whose study adds to the list of barriers with: documentation requirements to access some services; lack of transportation; limited healthcare capacity (including lack of translation services, cultural competency, and funding cuts); discrimination, shame, and stigma; the bureaucracy of the healthcare system; and limited knowledge of the healthcare system (Hacker et al., 2015, p. 177). Another study also identifies low acculturation, self-reliant attitudes, and large interpersonal support systems as obstacles that prevent the undocumented Latino community from seeking mental healthcare specifically (Cabassa et al., 2006, p. 12).

Socioeconomic Status. The generally low socioeconomic status of undocumented migrants contributes to their low rates of accessing and receiving care (Edward, 2014, p. 6; Perez & Fortuna, 2005). The literature identifies lack of education, type of occupation, and income as the three socioeconomic factors that have the biggest impact on one's interactions with the healthcare system, maintaining that individuals with high levels of educational attainment and an occupation that is financially sustainable are more likely to seek and receive healthcare (Edward, 2014, p. 6). Because the undocumented population are likely to work in low-skilled or low-level jobs, they are not provided with adequate

compensation or health insurance coverage as a result (Edward, 2014, p. 6; Enchautegui, 2015; Hacker et al., 2015).

Latino Culture. While "the usual healthcare barriers among immigrants including language, insurance, economic barriers, and documentation status" partially explain the underutilization of mental health services by undocumented Latino migrants, Fortuna et al., emphasizes the role that Latino culture plays in this issue (2008, p. 2). Alcohol abuse is one example: cultural norms about alcohol in Latino culture can cause someone who is a heavy drinker to not understand the problematic effects of this behavior (Fortuna et al., 2008; Moya & Shedlin, 2008, p. 1749).

Some cultural differences between Latino migrants and American mental health providers are rooted in how the respective countries view mental health, suffering, illness, and healthcare. Undocumented Latino migrants report feeling ashamed or hesitant to discuss their mental health and especially past traumas with medical professionals, and feel that providers often communicate with them in a way that causes discomfort (Fortuna et al., 2008, p. 2; Hacker et al., 2015, p. 178). This uncomfortable dynamic is only exacerbated by language barriers; a common experience of the undocumented community seems to be that the provider and the patient could not communicate with each other, often causing the provider to misunderstand or ignore their health concern (Hacker et al., 2015, p. 178). Furthermore, undocumented Latina migrants frequently suffer discrimination in the United States, which can cause reluctance to seek care for fear of unequal treatment or deportation (Edward, 2014, p. 6).

Lack of Information and Knowledge. A major barrier to care for undocumented Latina migrants is their general lack of knowledge about laws and policies regarding

immigration and health services (Hacker et al., 2015; Moya & Shedlin, 2008). Research has found that this population often does not know how to access and use the healthcare system, particularly when bureaucratic processes and procedures are required. They often do not understand their healthcare rights as an undocumented person in the United States, or what mental health services are available to them (Hacker et al., 2015, p. 178). There seems to be even more confusion and ambiguity in the discussion of substance use treatment for the undocumented (Moya & Shedlin, 2008, p. 1749).

In an interesting finding by Hacker et al., providers often have a lack of knowledge as well, misunderstanding or ignoring current policies on medical service access for the undocumented, leading them to turn individuals away under false pretenses (2015, p. 180).

Contemporary Policy: Immigration, Mental Healthcare, and a Divided America

Research by Friedberg et al., asserts that most Americans can agree on the idea that strengthening primary care will reduce healthcare spending and improve the overall health of the American population – regardless of immigration status (2010). This study concluded that high primary care physician-to-specialist ratios are directly linked to better health outcomes (Friedberg et al., 2010).

With this idea in mind, a few U.S. cities have already implemented programs to stop the disenfranchisement of undocumented immigrants from the American healthcare system. In New York City, the Health and Hospitals Corporation and the Community Health Care Association of New York State provide healthcare for uninsured and undocumented patients through Medicaid reimbursements and other state-level funding (Beck et al., 2017, p. 40). These organizations also provide patients with pharmacy and

specialist access, among other services that are typically near-impossible to access as an unauthorized immigrant in America. Beck and colleagues (2017) note that in California, the My Health LA program provides free healthcare coverage to residents of Los Angeles county, regardless of medical condition or immigration status, at 164 community clinics that administer primary preventive, and diagnostic care (p. 40). New York and California provide great models to achieving a more equitable United States and reducing the racially constructed barriers to care that undocumented immigrants in the country face. But as aforementioned, many undocumented individuals are still fearful and distrustful of using these services, proving that existing policy is not enough to cultivate sustainable health equity change.

Recommendations made by Hacker et al., to improve barriers to care for undocumented migrants include advocating for expansion of healthcare access and insurance coverage regardless of immigration status, delaying deportation for those currently receiving medical treatment, and legalizing the presence of these individuals in the U.S. so that they can be properly cared for (Hacker et al., 2015, p. 179). The authors of this study also suggested expanding health clinic capacity and funding, providing health education in social service/faith-based organizations, and altering training protocols for healthcare workers who care for migrant populations (Hacker et al., 2015, p. 179).

New treatment and access models that aim to destigmatize mental illness and substance abuse and provide culturally competent care to patients are beginning to pop up around the U.S.. The ideology of “harm reduction” and the Quality of Life (QoL) treatment-driven model are examples of public health initiatives that diverge from

traditional treatment that focuses on complete abstinence from substances (Moya & Shedlin, 2008, p. 1759). These models may help pave the way for policy and programs that include the undocumented community in comprehensive treatment tailored to fit their social, emotional, cultural, and financial needs (Moya & Shedlin, 2008, p. 1763).

The United States has a long way to go in terms of healthcare access for both its legal citizens and those who are undocumented. The healthcare system has evolved alongside immigration policy throughout the past centuries, but not in a correlational way. Current policy is clearly unfit to address this public health crisis, and "ambiguity in…policies related to the stipulation of authorized immigration status to access services further deters any advancement in the provision of healthcare for this population" (Edward, 2014, p. 7). Next steps are needed – whether those arise from the models employed by New York and California; from the recommendation categories of Hacker and colleagues' study; or from a completely new system altogether. The rest of this thesis explores areas of suggested change in an effort to create a culturally-competent and more equitable mental health care system.

CHAPTER FOUR: METHODOLOGY

Research Design

This study is designed to explore the interactions between undocumented Latina migrants and the U.S. mental healthcare system. It uses a cross-sectional qualitative research design that includes a literature and policy document review and key informant interviews with migrant women and service providers. Underscoring the goals of the study are four primary research questions:

1. What are the behavioral health needs of undocumented Latina migrants and why are these conditions or needs present?
2. What behavioral health services are available to undocumented Latina migrants in the Greater New Orleans area?
3. What are the perceived impediments to accessing care – from both the perspectives of the migrants and the providers?
4. What policy reform and advocacy work can be done to better the system and improve access for vulnerable individuals, specifically undocumented Latina migrants?

Much of the study is built upon primary sources: key informant interviews illustrate the personal experiences of undocumented women dealing with mental illness, as well as the experiences of providers in the healthcare system. These two perspectives give depth and breadth to the issue, complementing and contrasting, and ultimately illuminating how individuals reach the point of needing care, the modalities and approaches in use by providers, and the obstacles to getting effective treatment from both perspectives.

Research can rarely be separated from some aspects of the identity of the researcher, a concept which can be understood through positionality and reflexivity. Throughout the research process, I made sure to consider my own identity as a U.S. born, non-Latino researcher and student. A source of reflexivity in my research could likely be my background as a U.S. citizen who was also born and raised in the U.S. I have never – and will never – face the struggles of undocumented Latina migrants.

On one hand, these attributes could have introduced bias into my research, and I have kept this in mind throughout the entirety of the process. On the other hand, this may also bring other unique perspectives and experiences to this study. As a U.S.-born citizen, I am familiar with the country's systems and cultural norms. I have also lived in New Orleans, where this research is based, for four years and have had the privilege of working in various capacities with three different migrant serving organizations during this time. My prior experience with local organizations in the field provided me with an easier introduction to many of my study participants. Because I had already been acquainted with or was introduced by a mutual colleague to some of my study participants, my positionality as both a student and an acquaintance may have led participants to disclose information differently with me than they would have with a complete stranger (i.e., speaking more openly about sensitive information). On the flip side, these existing relationships could have also affected the way that I conducted these interviews (i.e., speaking in a more casual tone). In considering the positionality of the migrant participants, it is important to note that an individual's lack of documentation may have led to hesitancy to speak freely or with complete honesty while in the space. To account for this, I shared the preliminary findings of my research with members of my

study that expressed interest or curiosity about the results. The feedback from participants helped me to further refine the data, with the goal of most accurately communicating the sentiments and experiences expressed by each individual.

To further control for my reflexivity, I frequently revisited each of my transcripts and my codebook, trying to view the materials with a fresh pair of eyes each time. In addition, I consulted with my mentor from outside of Tulane on a weekly basis to talk through feelings or confusion that came up throughout the process. While she was not interviewed for this study, my mentor is a Latina migrant herself, and was helpful in re-centering and grounding my perspectives on this research when needed. I also presented the preliminary findings of my research prior to its final submission during a meeting at the organization I am employed at (the Institute of Women & Ethnic Studies) for feedback from the public health and social work professionals on my team. Lastly, I have spent much time reflecting on my own world views, belief system, and goals to consider how values of great importance in my life may impact my work and research.

As mentioned, participant recruitment was mainly done in collaboration with social service agencies in the Greater New Orleans area. Recruitment was done in cooperation with individuals and their respective organizations, such as providers at Federally Qualified Health Centers, hospitals, practitioners offices, social service agencies, and shelters in the region that serve migrant populations. Participants who expressed willingness to participate in the study were contacted to schedule an interview, either via Zoom or in-person, or by phone if necessary.

The length of the interviews was flexible due to the sensitive nature of the interview material and the conversational approach desired, but averaged around one

hour. Before the start of each interview, informed consent was obtained from the participant. Interviews were recorded and transcripts were used to code and qualitatively analyze the data. Original interview recordings were destroyed post-transcription and transcripts were scrubbed of all personal identifiers. The goal was to recruit and enroll 12 to 14 migrants and 12 to 14 to providers. Ultimately, 6 migrant women and 12 service providers were interviewed for this study.[3] Convenient sampling was employed in this study, as many of the migrant women interviewed were current or former clients of those in the provider group.

Data Collection

Inclusion Criteria

In order to participate in this study, the undocumented Latina migrant group must:

- Be over the age of 18
- Identify as Latina (i.e. woman and Latina)
- Born outside of the United States
- Be undocumented
- Speak English or Spanish

In order to participate in this study, the service provider group must:

- Be over the age of 18
- Provide services to undocumented Latinas in the study area
- Have the approval from their organization to speak about their experiences
- Speak English or Spanish

Data Sources and Collection Tools

The following table shows the study's main research questions and the data collection method and/or source(s) that were used to answer each question. Data for this study was collected through a literature and policy document review, and interviews with

[3]The implications of the goal number of participants vs. the number that ended up being recruited and enrolled are detailed in Chapter Six: Discussion.

Latina undocumented migrants and those who provide healthcare services to this population.

Research Questions and Data Sources	
Research Question	Data Source
What are the behavioral health needs of undocumented Latina migrants and why are these conditions or needs present?	Literature & Policy Review Migrant Interviews Provider Interviews
What behavioral health services are available to undocumented Latina migrants in the Greater New Orleans area?	Literature & Policy Review Migrant Interviews Provider Interviews
What are the perceived impediments to accessing care?	Literature & Policy Review Migrant Interviews Provider Interviews
What policy reform and advocacy work can be done to better the system and improve access for vulnerable individuals, particularly undocumented Latina migrants?	Literature & Policy Review Migrant Interviews Provider Interviews

Table 1: *Research Questions and Data Sources*

Interviews were semi-structured; an interview guide with prepared questions and topics was used to guide the conversation, though participants were encouraged to discuss whatever felt important to them throughout the session. Two interview guides were used for the study, one for each type of key informant. The guide was available in English and Spanish so that individuals could participate in the study in the language of their choosing; in other words, interviews could easily be conducted in either English or Spanish. Each guide follows the same basic organizational structure, with participants first being prompted to explain their personal and/or professional narrative, then a discussion of care provided/received, challenges and obstacles, and finally suggestions for improvement of the mental healthcare system in the United States.

Data Analysis and Data Collection Management

All personal information and identifiers was removed from interview transcripts. Each interview was coded to use in analysis and presentation of results. All data related to the study was stored in secure Box files which were password protected to ensure maximal confidentiality.

Using thematic content analysis, the information gathered from the literature and policy reviews and both sets of interviews was coded and interpreted to identify patterns of meaning within the qualitative data. The general procedure used to analyze the data thematically was suggested by Braun and Clarke (2006), and is as follows: (1) identify and familiarize with data, (2) identify codes, (3) find themes in data, (4) finalize themes, (5) review each theme, (6) document analysis.

Risks

Risks for this study were considered to be minimal; despite the sensitive nature of the data that will be collected, all participants remained completely anonymous. Additionally, all participation in the study was voluntary and subjects could opt out without consequence at any time throughout the research process.

To further mitigate any potential harm to participants, a confidential wellness check was conducted 48-72 hours after the completion of the interview. All key informants were contacted via their preferred method of communication to ensure their welfare and were offered referrals to trained counselors or other resources for additional support if needed or desired.

Benefits

Participants may have benefited from the study by being able to voice their concerns and experiences about the mental healthcare system in the United States and the way that it serves, or fails to serve, undocumented Latina women. While their identities remained anonymous due to the sensitive nature of the subject and vulnerability of the population, participants were given the opportunity to make their voices heard in a confidential, but very meaningful, way.

There were no other direct benefits to participants from this research, although the policy recommendations that conclude this thesis aim to be grounds for future social change that will positively affect undocumented immigrants around the United States.

Remuneration & Costs

There will be no remuneration provided to subjects for their participation in this study. There are no costs to the subjects of the study, with the exception of the minimal time commitment required for the interview.

Informed Consent Process and Documentation

Ethical approval for research on human subjects, particularly given the vulnerability of the study population, was completed through Tulane University's Institutional Review Board. The primary researcher explained the study, its purpose, and its procedure to the participants prior to the interviews. All willing participants were given informed consent forms to sign; interviewees were not required to answer any questions that they did not wish to and could terminate the interview process at any time. Consent forms were kept private throughout the duration of the study.

CHAPTER FIVE: RESULTS

Interview Outcomes

All interviews were conducted between October 2022 and January 2023 via phone call, the Zoom video conferencing platform, and in-person meetings. Participants from the undocumented Latina migrant group strongly preferred to partake in interviews over the phone; no one from this group elected to participate in a face-to-face interview and only one chose to meet using Zoom. The average interview length for this group was 42.16 minutes (μ=42.16; σ=9.79). Participants from the provider group seemed to prefer participating in interviews via Zoom, though none of them expressed a strong desire for one interview platform over another, unlike the migrant group. The average interview length for this group was 48.58 minutes (μ=48.58; σ=9.69). The table below provides further information about the nature of each interview.

Table 2. *Interview Map*

	Migrant or Provider	Date of Interview	Interview Platform	Interview Length
Interview 1	Migrant	10/17/2022	Phone call	41 minutes
Interview 2	Provider	10/21/2022	Phone call	57 minutes
Interview 3	Provider	11/11/2022	Zoom	53 minutes
Interview 4	Migrant	11/15/2022	Phone call	32 minutes
Interview 5	Provider	11/29/2022	Zoom	59 minutes
Interview 6	Provider	12/05/2022	Zoom	51 minutes
Interview 7	Migrant	12/20/2022	Phone call	55 minutes
Interview 8	Migrant	12/20/2022	Phone call	46 minutes
Interview 9	Provider	12/22/2022	Zoom	38 minutes
Interview 10	Provider	12/28/2022	Zoom	46 minutes
Interview 11	Migrant	01/04/2023	Phone call	49 minutes

Interview 12	Provider	01/09/2023	Zoom	62 minutes
Interview 13	Migrant	01/09/2023	Phone call	30 minutes
Interview 14	Provider	01/12/2023	In-person	58 minutes
Interview 15	Provider	01/17/2023	Zoom	32 minutes
Interview 16	Provider	01/23/2023	Phone call	40 minutes
Interview 17	Provider	01/24/2023	Zoom	48 minutes
Interview 18	Provider	01/27/2023	Zoom	39 minutes

As indicated in the study procedure, each participant was contacted within 48 hours of their interview via their preferred method of communication to check on their well-being. There were no reports of emotional or physical distress as a result of the interview process, though during the interviews multiple participants did disclose having experienced sexual assault and other forms of trauma.

Participant Demographics

Undocumented Latina Migrant Group

All six of the migrants interviewed identified as being female and of Hispanic/Latino origin. None were citizens of the United States at the time of interview. The ages of participants ranged from 29 to 48 years and 5 out of the 6 women had at least one child with them in the U.S. The average length of time spent in the U.S. by participants was 5.7 years (μ=5.7, σ=2.7), with countries of origin for these women being Guatemala (2), El Salvador (1), Honduras (1), and Mexico (1); one woman did not disclose her country of origin.

Provider Group

Out of the 12 participants in the provider group, all but one identified as female; one identified as male. Every provider interviewed identified themselves as bilingual in

Spanish and English, with 7 out of 12 reporting that English was not their first language. The average length of time in practice by participants was 12.2 years (μ=12.2, σ=7.4). Four providers reported employment as a social worker at social service agency, three served as program managers and one as a program director at public health non-profit organizations, two worked in hospitals or clinics providing direct medical services, and two worked in the legal field – one as an attorney for a non-profit organization and one as a DOJ accredited representative for a social service agency. Two of the twelve providers reported currently holding an executive leadership position at their place of employment. Multiple providers discussed the migration experiences of their families (sometimes including themselves and sometimes solely referencing parents or extended family members) from Latin American countries to the United States. Countries of origin for this group included the United States (5), El Salvador (2), the Dominican Republic (1), Guatemala (1), and Peru (1); two providers did not disclose their country of origin.

Thematic Organization of Results

Data from the provider and migrant interviews – when compared against data compiled from the literature review – generated themes within the current landscape of mental health care services for undocumented Latina migrants. These themes were sorted into three categories based on the goals presented by the research questions of the study[4]: (1) behavioral health needs of undocumented Latina migrants and (2) existing services, including those in the Greater New Orleans area, and (3) impediments to accessing and receiving care. Because of the deeply interconnected nature of these issues, the findings

[4] Research questions of the study include: (1) What are the behavioral health needs of undocumented Latina migrants and why are these conditions or needs present?; (2) What behavioral health services are available to undocumented Latina migrants in the Greater New Orleans area?; (3) What are the perceived impediments to accessing care – from both the perspectives of the migrants and the providers?; and (4) What policy reform and advocacy work can be done to better the system and improve access for vulnerable individuals, specifically undocumented Latina migrants?

may overlap between categories; their organization alongside the research questions simply intends to frame the results, not define or limit their applicability to the issue as a whole.

(1) Behavioral Health Needs of Undocumented Latina Migrants

One of the main objectives of this research was to gain a fuller understanding of the mental health needs and concerns of undocumented Latina migrants. In the key informant interviews, participants expressed a variety of feelings and conditions deserving of mental health services. The women specifically identified depression and anxiety as the primary mental health conditions that they have identified in themselves or in women around them. The interviews with both the migrant and provider participant groups revealed numerous mental health pressures, including: feelings of isolation and loss of hope; coping with trauma; substance abuse; struggles with gender and family roles; and difficulty navigating the COVID-19 pandemic. Generally speaking, all six migrant participants described feelings of stress or worry while in the United States due to these and other factors. Four of the women indicated they had sought some sort of mental health service, while two said that they had not.

Feelings of Isolation and Loss of Hope

A common mental health theme among the Latina migrant participants was a generalized feeling of hopelessness and isolation. This group frequently referenced their loss of hope in the very ideal that motivated them to leave home for this utopian premise: the "American Dream." For many undocumented Latina migrants, this dream – a century-old, idealistic conception of the opportunities available in the U.S – never becomes a reality. The participants spoke of the trajectory of their migrant experience, as

parents yearning to give their children a better life in the U.S., followed by the pain of not being able to actually achieve this goal. They described a constant feeling of having fewer opportunities than citizens, and of being confronted with systems that seem designed to reinforce their non-citizen status. One woman explained this feeling, saying, "I have never been legal anywhere in my life…I know the government does not want me here and they do not want my children here."

This feeling of not being wanted is compounded by the isolation – both real and emotional – of undocumented women. Study participants talked about how Latina migrants in the U.S. often lose much of the interpersonal support system offered by their families and culture, which leads to loneliness and isolation, which in turn contributes to depression, and other mental health conditions.

Trauma, Abuse, and PTSD

Trauma and abuse were either directly mentioned or alluded to by all of the undocumented Latina migrants who were interviewed, with the trauma of the migration experience being one of the most common themes in these conversations. The migrant group told stories of struggling to cross the border with their children, or having to leave their children behind; of being kidnapped; of watching their child fall ill and not being able to help them. In one interview, a woman described her traumatic journey to the U.S., which is paraphrased below for brevity and the privacy of the participant.

> Maya[5], now 38 years old, migrated from Guatemala to the United States because she was being stalked by an ex-boyfriend. She was raped while crossing the border between Mexico and Texas; shortly after making it to the U.S., she was

[5] Name of the participant has been changed for their privacy; this name bears no significance to the research conducted.

> raped again by a different assailant. She became pregnant, but was unsure which of her rapists was the father, and ended up starting an intimate relationship with the second man, who she says physically and mentally abused her for years. Maya visited a clinic in Texas, where she says she was encouraged by a provider to get an abortion, to which she replied, "No! It's a baby!" She ended up having a baby girl. She did not disclose if she is now aware of the identity of the father. The man continued to abuse her after the birth of her child and she became depressed. Maya realized that she did not want her daughter to face this same trauma, and said that her and "a friend" left Texas and ended up in the Greater New Orleans area. She is now a member of a support group for victims of domestic violence and was prescribed a medicine for her *ansiedad* (anxiety), but she says she no longer takes it.

This story provides an example of the traumatic experiences of Latina migrants before, during, and after migration and reflects their resulting mental health needs. Despite being a victim of stalking, rape, and physical and mental abuse, Maya explained that she did not seek help or protection in the U.S. for fear of detainment or deportation.

In their interviews, providers pointed out that migrant women facing mental illness due to trauma and abuse may not realize their condition unless they sit down with someone who can diagnose the symptoms and conditions. The providers reported identifying symptoms of PTSD in migrant women, including those who experienced childhood trauma – noting that these women may have been experiencing the implications of abuse and trauma since childhood or early adulthood.

Substance Abuse

It was difficult to elicit personal experiences with substance use and abuse from the migrant participants. Most of the women described drinking as a common activity but not as a problem. They said that alcohol is not typically considered a drug in Latino culture, and furthermore, they viewed substance abuse as separate from mental health. However, in contrast to this perspective, providers (and the literature) identified SUD as a prominent mental health issue in this population. The providers said they had Latina migrant clients who used alcohol to deal with mental health issues such as stress and loneliness, feeding potential addiction. They noted that often substance abuse goes untreated, stemming from the cultural discrepancy between what Americans identify as a "mental health disorder" versus what Latinos accept as "healthy coping behavior." In this regard, the provider interviewees presented a discernible need for services to treat co-occurring mental and substance abuse issues in the Latina migrant community.

Gender and Family Roles

While the terms *marianismo* and *machismo* were not referred to by name in interviews, all but two of the study's participants said traditional Latino gender and family roles were factors in the mental health needs of the undocumented Latina migrant population. Migrant women and providers depicted tension and struggle over navigating issues such as routine medical care, harsh family disciplinary practices, and teen pregnancy.

One woman explained that while she avoided doctors and the healthcare system, "when my children are sick, we go to the doctor. But me, I do not go. I do not like to go." A provider recounted how mothers and fathers she met with were experiencing stress and

confusion over how they could discipline their children. She said that she had to explain to them that if they used the same harsh methods as they would in their home countries, their child could be taken away and/or they could be deported. Both of these anecdotes represent the kind of scenarios where mental health services could be used to help Latina migrants.

The mental health impact of teen pregnancy was among the most common themes raised by providers. They described women being locked into relationships with men who are sexist or misogynistic, fostering a variety of emotional and psychological problems warranting care. The providers and the literature point to relatively high rates of teen pregnancy for young undocumented Latina migrants, which the interviewees said was facilitated, in part, by the patriarchal structure of Latino families. One provider said that many of her clients are undocumented teenagers (or the children of undocumented parents) who are pregnant – often by men they had just met. But these girls and young women often did not see this as a problem, or recognize the impact the relationship was having on their mental health. In fact, the participants who spoke about teen pregnancy made it clear that they love and value the closeness and functionality of their families. The interviews and research show a complex dynamic at play: problematic relationships and gender roles coupled with devotion to the same family and culture that promotes them.

Misinformation & COVID-19

The pandemic caused a host of mental health issues and needs for many segments of the population. For migrants, the COVID-19 pandemic instilled fear, confusion, suspicion, stress and anxiety. At the heart of some of these issues was the susceptibility of

the migrant community to misinformation or even the outright lack of any information at all. Women from the migrant participant group expressed feeling trapped during the pandemic, but unsure of how to work through the stress and anxiety they were experiencing. They also recounted a heightened worry over being discovered and deported. Explaining how misinformation affected the mental health of her community, one participant said:

> *A lot of people were stressed because nobody knew what was going on. There was all the bad information from the Internet, from Facebook, from YouTube, that says the vaccine is going to give you this disease, or they're going to put a chip in you and ICE is going to go find you and then you're going to get deported and your kids are going to be left here.*

This kind of fear based on misinformation seemed to reinforce pre-existing behavioral health issues, creating a toxic cycle where the more misinformation the community received the more stressed and anxious they became. The misinformation situation intersected with what providers described as a persistent lack of basic good information; one provider said that undocumented women often "...don't have a lot of information on how to get from point A to point B," especially if they do not know English. This disparity reinforces migrants' feelings of being trapped, isolated and anxious, which led the provider to start teaching "...basic things, like how to use coupons for going in to buy food, or how to write an application, or how to enroll… children in school."

(2) Existing Services in the Greater New Orleans Area

The second objective of this thesis was to identify what behavioral health services currently exist for the undocumented Latina community and how these services are being provided. This section draws heavily on the experiences of providers but also reflects the corroborating or contrasting accounts of Latina migrants. Providers in this study worked

in a variety of different roles in the mental health and migrant services area, some in the legal field, at social service agencies, at healthcare clinics (FQHCs) and hospitals, and at public health non-profit organizations. While not all-encompassing, the information shared by participants about their places of employment provide a snapshot of the behavioral health services that are available in the Greater New Orleans area. See Table 3 for a record of existing mental health care services in the area for undocumented Latina migrants; it is not necessarily inclusive of every local care provider.

In terms of clinical mental health services, New Orleans' FQHCs and community health centers operate as networks of health centers for primary care and behavioral health. They provide services regardless of immigration status because they do not require insurance for care. They are able to do this due to their federal funding and sliding payment scale, which allows patients to pay what they can afford for the care they received. Providers familiar with the FQHC network said that they are constantly met with high patient demand, most of whom come through the door as referrals from social service agencies or friends and family. They said that most of these health centers have bilingual staff, but not in abundance.

There are a host of social service agencies in New Orleans that also offer services to the undocumented community, but they are notoriously under-staffed and under-funded, according to gray literature and provider interviews. The providers said that these agencies typically tend to focus on treatment for SUD/addiction and housing assistance, though most social service agencies in New Orleans address mental health in one way or another.

Table 3: *Mental Health Care Services in New Orleans for Undocumented Latina Migrants*

Organization	Service(s) Provided
Access Health LA | South Broad Community Health Center	Adult primary care, behavioral health, diabetes education classes, free HIV home testing, health coaching, pediatrics
Bridge House/Grace House	Long-term residential substance-use disorder treatment programming
Catholic Charities Archdiocese of New Orleans	Pro-bono immigration and refugee representation, ELL and citizenship classes
CrescentCare	Three categories of care: whole person healthcare, and care for a diverse community
DePaul Community Health Center	Behavioral health services include counseling, medication management, and psychiatric evaluations
Metropolitan Human Services District	Four categories of care: intellectual/developmental disability, child & youth, adult, and general support
National Alliance on Mental Illness New Orleans	Community Psychiatric Support and Treatment, Psychosocial Rehabilitation Skills Training, counseling, drop in support center
New Orleans Family Justice Center	Crisis services and shelter, advocacy and case management, legal, counseling, healing activities, youth & teens, hope clinic
Program Believe	Immigration legal services and educational services (ELL, GED, computer)
Puentes	Disaster recovery, medical care, immigration and legal services, emergency housing/domestic violence, LGBTQIA
St. Thomas Community Health Center	Behavioral health services include counseling, medication management, and psychiatric evaluations
Start Community Health Center	Behavioral health services include counseling, medication management, and psychiatric evaluations
The Pro Bono Project	Pro bono legal services in a variety of areas
UNITY of Greater New Orleans	Outreach, crisis line, case management, employment assistance, medical care, mental health services, substance abuse treatment, HIV/AIDS services, domestic violence services, legal services

The lack of adequate funding was mentioned by all 12 of the providers interviewed; each of them expressed that their organization did not have enough money

to meet the needs of the migrant population in the Greater New Orleans area. One provider, who works at a social service agency, referenced an organization at which she was formerly employed, saying that while more funding was certainly needed, the funding that was available created disparities within the agency itself. She said that clients who spoke English were prioritized by the organization – which offered GED classes for undocumented Latina migrants that were English-speakers. No classes existed at the organization for clients that solely spoke Spanish. Another main avenue for services is through larger, religious-affiliated non-profit organizations in New Orleans. Providers described these organizations as having slightly better funding but barely any capacity at all, meaning that they have to turn most people away.

(3) Impediments to Accessing and Receiving Care

Participants identified a multitude of factors that posed barriers to mental health care for undocumented Latina migrants, including cultural, systems, and organizational level issues. Cultural barriers highlighted in this section include lingual differences between Spanish and English; Latino beliefs about health, illness, and medicine; and religiosity. Systemic barriers include the inequitable systems and opportunities appropriated to the undocumented community, and the related impacts of cultural lumping, poverty, and technology. The third category of impediments – the organizational – discusses staff, finances, and diversity.

Cultural Barriers

Language Barriers at Migrant-Serving Organizations. Providers discussed at length the lack of interpretation services – especially in mental health care – and the impact of this disparity on their clients or their organization. For example, interviewees

spoke of how children are often required to act as interpreters in situations that are far beyond their maturity – in addition to being illegal. One provider described a Spanish-speaking former client who brought her young daughter, who was bilingual in Spanish and English, to her follow-up doctor's appointment. Her English-speaking provider told her that she had cancer, but because of the language barrier, the daughter was forced to relay the diagnosis back to her mother in Spanish. Another provider discussed the lack of Spanish-speaking police officers, noting that this is particularly problematic when an English-speaking officer is using a child as an intermediary in stressful, complicated, and potentially dangerous situations such as those involving drugs, domestic violence, etc.

Speaking usually in a broken mix of Spanish and English, the migrant women explained that it's not that they don't want to learn English, the problem is the lack of accessible opportunities to do so. Women described being aware of English language classes offered by various community organizations, but explained that the necessity to work and care for their families has to take precedence over going to these weekly sessions. One interviewee cited an evening English Language Learner (ELL) class hosted by a local faith-based organization, but explained that she was hesitant to attend because her friend told her that there was a sign-in sheet that required participants' full name and two methods of contact information.

One woman who migrated to the U.S. with her young daughter in 2018 said in her interview that when she visited her local clinic for a mental health concern, she was told to come back the following day when a bilingual staff member would be present for interpretation. When she returned the following day, that individual was nowhere to be

found. This lack of reliable language services was echoed by providers who explained that some agencies say that they provide services in English and Spanish, but that may only mean that most staff speak either English or Spanish – not both.

Underscoring all of these issues seemed to be the lack of Spanish-speaking Latina mental healthcare providers. These professionals are in such high demand that individuals with other areas of expertise are often forced to act like counselors or psychologists to patients who cannot receive these services elsewhere. This problem, according to the study participants, frequently occurs in emergency rooms and health clinics, where someone who specializes in endocrinology, for example, will see an undocumented Latina patient because they are presenting symptoms of diabetes but the entire appointment is spent discussing their mental health instead. This barrier to adequate care posed by language is also well documented in the literature and cited as a key contributor to disenfranchisement and creates a vicious cycle. One provider summarized this cycle, saying:

> *When you move to a different country, you don't have the language and you don't know the culture. So I have started seeing a lot of undocumented ladies get depression and anxiety because you don't have access to the medical system. You can go to a clinic and if you have the money to pay, you will be seen, but if you cannot explain how you feel, and if this clinic doesn't have an interpreter, you won't be able to tell the doctor how you feel and you will have no help.*

Participants expressed their frustrations around what felt to them like a performative attempt at diversity, equity, and inclusion strategies (DEI), with one provider saying: “Just because you have one staff member who speaks Spanish does not mean that your organization is diverse. That pisses me off, because it's like, ‘Oh, so you expect this one person just to do everything related to that?’” This sentiment speaks not only to the lack of Spanish-speaking providers in the mental health field, but also to the

disconnect between what is *currently being done* and what *needs to be done* in order to improve the delivery of care for this community. Cultural and lingual literacy go hand-in-hand for those who provide services to the undocumented Latina migrant population; participants explained that one without the other is much less effective. As one provider said:

> *I am not a psychologist, but I know the culture and that's the difference. I can go to a psychologist but if the psychologist doesn't know my culture, it won't help me. It's not only to be a bilingual person, it is to know the culture, so that's the difference and that's what we need.*

Latino Beliefs About Health and Medicine. Avoidant health behaviors have a deep cultural history for Latina migrants, and are a formidable obstacle when it comes to accessing mental health care. In their countries of origin, many rely on a *curandera* (a healer who uses natural folk remedies) rather than a doctor who practices Western medicine. The study participants reported that feelings of unfamiliarity with – or skepticism of – the American medical system were common in the community and contributed to reluctance to seek mental health care. A woman from the migrant group described feeling comfortable relying on natural remedies and the power of fate in times of sickness.

Participant interviews highlighted an important distinction when it comes to medical care: especially in less affluent parts of Latin America, there is not a widespread preventative approach to health and health care. This sharply contrasts with the overall approach in the U.S., where preventative care is emphasized. Migrant participants talked about only going to the doctor in emergencies, or when they were in “a very bad condition.” A provider told a story of a client who was prescribed an antidepressant to help her symptoms of Post Traumatic Stress Disorder (PTSD), but would only take her

medication when she was feeling anxious or upset rather than everyday, as is required to mitigate symptoms of the condition.

Interviews with providers and undocumented Latina migrants showed a varying understanding of mental health among this population. Latina migrants may not have been previously exposed to the kind of health resources that exist in the U.S., and this lack of exposure contributes to unawareness that these services even exist. One provider explained this obstacle to care this way: native English-speakers reap the benefits of the U.S. mental healthcare system, while migrants come to this country, "not knowing the resources that are available to them and then not even being able to communicate with people so that they can find out what resources do exist."

Religion. Migrant participants said that because of the importance religion plays in their cultural and family backgrounds, they oftentimes felt more comfortable accessing care in the U.S. that is religiously affiliated. One woman referenced the comfort in knowing that she may share Catholic values with her provider. Three providers either currently or formerly worked for an organization that was affiliated with the Catholic Church or that received funding from another religious entity. They explained that as employees of an organization with certain religious values as its core, certain guidelines that they had to adhere sometimes clashed with best practices in public health or with their own values. One provider shared the example of a newly pregnant undocumented Latina migrant who was being assisted by the organization's legal team as they worked to get her asylum in the U.S.. This woman, who the provider described as being "quite young," was a survivor of domestic violence, had a history of trauma in her country of origin, and was diagnosed with Major Depressive Disorder (MDD). The provider

explained that despite wanting to suggest that the client speak with someone about the option of abortion, this was against the organization's rules.This conflict between religion and effective care was reported as a barrier, but at the same time should not be overstated because many of the participants expressed appreciation for the support religious institutions provide. It is an important subject to bear in mind in thinking about how to effectively provide care to this population and navigate hot-button issues like abortion that are also prevalent in mainstream American society.

Systemic Barriers

Cultural Lumping. The term "cultural lumping" refers to how Spanish-speaking migrants in this study described being grouped into the "Hispanic" or "Latino" category, despite identifying as something else or something in addition. For example, one woman highlighted the importance of her Afro-Latina background to her personal identity, but said, "Here, I am Black *or* I am Spanish," referencing the cultural ignorance that she experiences in the United States. Other migrant participants explained how they feel American systems think of their country of origin as being identical to every other Spanish-speaking country, effectively broad-brushing their differences and stripping them of certain aspects of their identity and culture. In this way, interviewees explained that "cultural lumping" can be a critical barrier to effective diagnosis and care because it fails to take into account an individual's totality and complexities.

Poverty. Systemic and seemingly inescapable poverty was a common problem cited by both types of study respondents. For many of these undocumented Latinas migrants, poverty is not simply the condition of not having enough money; poverty for the undocumented woman was a condition of criminalization, exploitation, and

dehumanization. One participant described her status as an undocumented woman in the U.S. as being "worse than the [American] homeless." She noted that even the poorest citizens of the U.S. have more mobility and are more welcomed by systems like healthcare and the government than the undocumented. A provider explained the situation this way:

> *People want to work, people want to eat, people want to have their things, but if you want people to always feel 'less than,' we will continue to have this problem. We need to understand that we are all human beings. This small group of people that has the power always wants more, but this big group that is the base is not being taken care of. The small group only takes care of the small group.*

The disenfranchisement described here, at its core, is racial and hierarchical; undocumented women of color are repeatedly and systematically neglected by white Americans. As a result, many undocumented Latina migrants are in a state of socioeconomic disadvantage that can pose a profound barrier to the delivery of mental health care. Their lack of resources and the systemic barriers to acquiring them tethers this population to further marginalization.

One provider, who was formerly undocumented, said even within the ranks of mental health care there can be an undercurrent of anti-immigrant discrimination."We like to think that everybody in these public service roles isn't going to be discriminatory, but that's not necessarily true," the provider said. A participant from the migrant group described the manifestation of such discrimination, recounting an experience at a local food pantry where the staff seemed to only want to provide food to white people, effectively excluding members of her community from this necessary service.

Technology. In the past 15 years, the U.S. has fully entered the Digital Age, facilitating the full immersion of technology (in various forms) into nearly every facet of

daily life. The COVID-19 pandemic accelerated this movement, causing the American healthcare system to move more towards online access to services and information. This poses an additional barrier to undocumented Latina migrants, as some of these individuals do not have access to a smartphone, laptop, or email, and are not fluent or confident using these kinds of technologies. One participant from the migrant group exclaimed, "And I have to use the email to make an appointment?!" This frustration was echoed by many others – including a provider, who noted that:

> *When you're having to get an app and set up an account just to make a doctor's appointment, or you need to go to a website and fill out a form just to get an appointment with an attorney, that can be a real burden.*

The provider chalked this up to cultural differences between American and Latin American systems; she explained that while in the U.S. it is normal to email a doctor or leave them a voicemail, technology is not so ingrained in the healthcare system in many Spanish-speaking countries. But on a larger level, this technology barrier is indicative of the systemic inequities that exist for marginalized communities.

Organizational Barriers

Overwhelmed Referral Processes. In the field of service provision for the undocumented community, referrals are an absolutely essential mechanism of client acquisition, management, care, and rehabilitation. Some organizations are primarily referred to by immigration agencies at the border (who are eager to pass off newcomers as quickly as possible), while some are part of networks that refer to one another based on client needs and organizational capacity, among other factors. Still other organizations rely on word-of-mouth referrals, where a client speaks about their care experiences to

members of their community, who may seek out this same care as a result. One provider explained how this works in practice, saying:

> *We have a specific support group for the women who are Spanish-speaking immigrants…led by my supervisor at the time. She was working with the agency for quite some time and so they developed a really tight community in the group. This same group of women would recruit other women and try to bring them in, which helped the group grow and grow.*

Based on the interviews and literature, it appears that for most agencies, the number of people that are referred to them far outweighs the number to which they can provide services. One provider at a large non-profit said that their organization receives around 1,000 calls per month, but that they can only take about 20 of them as clients. This results in waitlists that are often years long, leaving undocumented individuals waiting, consumed by anxiety, "to get a phone call, to have a counselor, to have a caseworker, or just to have somebody that can help them through the crisis that they are experiencing," a provider explained. Even when an organization does accept an individual as a client, this does not necessarily mean that the services they will be provided with are adequate. Because of the lack of case managers at many migrant-serving organizations, providers in other roles are often left to pick up the slack. One provider, who currently works as an attorney, described accompanying a client – whom she had just helped receive asylum – to the DMV and the social security office, saying, "I had to, or no one else would, and it wouldn't get done. But it's not in my job description!"

Provider-Client Relationships. The racial/ethnic backgrounds of staff at migrant-serving organizations was cited as an obstacle to effective service. Study participants, both providers and Latina migrants, noted that frontline staff and leadership

are often not Latino/Hispanic. When these positions are held by white men and women, the participants explained, it can become an unintended barrier to effective support compared to the way someone with a Latino background might be able to provide services.

Providers with migration experience specifically spoke about the struggles of dancing between being both "the colonized" and "the colonizer" in mental health work. During one interview, a provider who self-identified as Dominican said:

> *We have this idea of white savior because we have built this institution where when you enter a space and see visually that people are in need of support, you do what you feel and what you assume is right. You don't sit there and try to get to know the community, get to know what their values are, and empower their dignity.*

Though they well understood that mental illness is highly stigmatized in Latino culture, many providers said they felt culturally disconnected from their clients because of their expertise, and at times even had opposing viewpoints on issues relating to mental health and wellbeing. Providers explained that this speaks to the importance of taking a compassionate approach to service provision, saying:

> *I can't say, "Do this," because that is the way* I *think; I say, "Of course!" and I go with them. I have to meet them where they are…I don't think you can change people's lives – you don't change people's lives. I wish. But I do think I can help them to see who they are and the possibilities they have.*

This method of lifting up a clients' autonomy and honoring their unique identities was described to be both essential to provider success and to client wellbeing. Providers also described feelings of frustration in their line of work, because they felt as if they recognized mental illness in their clients, but that the client would not accept the diagnosis nor fix it. One participant from this group explained, "We [providers] hope that

we can do something, but it is the person who has to…help themselves. There can be a lot of help, but if they don't want it then what we do is useless."

Impact on Providers. In their interviews, providers explained how their methodology and lived experience impacts the work that they do. Participants in this group frequently mentioned the effect that working in this field has on their own mental health, and some identified coping strategies they use as a result, such as speaking to a therapist outside of their organization. One provider explained that "with some clients, it's kind of a done deal - and then some clients really hit you;" another echoed this sentiment, saying, "I connected with a lot of the women and it was really hard to say goodbye, because I knew that I was leaving them, with no one to fill in my spot." This emotional burden on the provider impacts the way they are able to care for their clients and may lead to burnout and quick staff turnover, which in turn further complicates the migrant experience in navigating the mental health care system.

CHAPTER SIX: DISCUSSION

This section will discuss the results of my research. I was able to interpret the results of my four primary research questions by comparing the larger behavioral health and immigration landscape with data from current literature and policy – as well as with my own expectations. After interpreting this study's findings, I discuss the implications of my results, explaining why they matter in a public health context and beyond. Next, I identify a few key limitations of the study, and conclude by providing recommendations for reform. My fourth research question (What policy reform and advocacy work can be done to better the system and improve access for vulnerable individuals, particularly undocumented Latina migrants?) is answered in the recommendations section of this chapter.

Summary

Behavioral Health Needs of Undocumented Latina Migrants

In investigating the specific behavioral health needs of undocumented Latina migrants, depression, anxiety, and PTSD were the most referenced mental health conditions. Participants described feelings of isolation and loss of hope; trauma, abuse, and PTSD; substance abuse; gender and family roles; and misinformation (or the lack of any information at all) about mental health. I found that undocumented Latina migrants in the U.S. often feel isolated due to cultural differences, their non-citizen status, and the loss of the familial support they were used to in their home countries. Trauma and abuse were cited by all the undocumented Latina migrant participants; and providers frequently connected the dots between push factors for migration, the trauma of migration and poor mental health outcomes. The migrant women I interviewed were largely unaware that

their symptoms were indicators of past trauma, unless a mental health professional provided them with a diagnosis. I also found that many undocumented Latina migrants are incognizant of possible substance abuse, largely because alcohol is not typically considered a drug in Latino culture, and because substance abuse is generally not viewed as a mental health issue. That being said, providers stated that alcohol was the substance that they observed being abused by this population the most.

Latino cultural norms, such as a patriarchal family structure, were the source of some behavioral health concerns. The participants' discussion of teen pregnancy, harsh family disciplinary practices, and romantic relationships were dominated by themes of misogyny – all of which are inherently connected to mental health problems. However, I also found that participants regularly mentioned their love of and devotion to the family structures and norms of Latino culture, despite American cultural disapproval. The study also revealed a lack of proper information about American systems and way of life, only exacerbated by the COVID-19 pandemic.

Existing Services in the Greater New Orleans Area

This study also aimed to understand the landscape of currently available behavioral health services for undocumented Latina migrants in the Greater New Orleans area. I found that services in this area are handled by non-profit organizations, social service agencies, and FQHCs or community health centers, because these are the care networks that will provide services regardless of insurance or documentation status. Many offer care for free or on a sliding scale. But even when organizations claim to provide care to non-citizens, the undocumented community largely remains skeptical and hesitant. New Orleans' nonprofits and social service agencies struggle with a lack of

funding and staff (especially Spanish-speaking, Latina providers), though they were generally described as understanding and aware of the needs of their clients. FQHCs and community health centers in the Greater New Orleans area are typically federally funded and are inundated with demand. Similar to the nonprofit agencies in the area, they do not have enough bilingual and bicultural providers to properly serve the undocumented Latina community.

Impediments to Accessing and Receiving Care

My findings on mental healthcare impediments for Latina migrants are one of the most important components of this study, through which three barrier categories were identified: (1) cultural, (2) systemic, and (3) organizational. Key informants cited language differences, religion, poverty, and traditional Latino approaches to illness and medicine as obstacles to accessing the U.S. mental healthcare system. Participants also specified inequitable systems and opportunities available to the undocumented community; the related impacts of cultural lumping, poverty, and technology; and staff, finances, and diversity as barriers of particular importance to this issue.

Interpretations

Anecdotes from participant interviews generally affirmed findings from literature and policy review. Both the existing literature and key informant interviews identified the traumatic migration experience as one of the most impactful factors to an individual's mental health and their likelihood to access care. The literature identified the migration experience as a determinant of major depressive disorder among Latino migrants, indicating that many undocumented Latina migrants feared for their life or their safety during migration, identified migration as causing them significant stress, and experienced

a traumatic event such as a violent attack during migration (Ornelas & Perreira, 2011, p. 1176). These sentiments were echoed in my own study, with women recounting harrowing tales of family separation, rape, and physical violence during the migration experience. Providers affirmed that such experiences are very likely to induce PTSD and other mental health issues, but that many migrants remain unaware of their condition unless they see a mental health professional.

Existing literature shows that undocumented Latina migrants present more concurrent psychological stressors and issues in regard to acculturation, health care, the legal system, and occupation status than their documented counterparts (Garcini et al., 2017; Perez & Fortuna, 2005; Yu et al, 2020). While the methodology of this study did not include comparison across varying documentation statuses, I also concluded that these issues are major contributors to stress and anxiety among the migrant population and are likely negatively impacting their mental health and their interactions with the health care system.

Furthermore, Lewin and Altman's description of the U.S. safety net healthcare system as "a patchwork of providers, funding, and programs tenuously held together by the power of demonstrated need, community support, and political acumen" is in line with sentiments I heard from providers, who said their organizations did not have the funding or staff to meet community need, but that the dire predicament of Latina migrants kept their organizations working despite lack of resources (2000, p. 17). In addition to the shortcomings of the behavioral health system itself, both the literature and key informant interviews identified several factors as determinants of the mental health of undocumented Latina migrants. Those factors include poverty, lingual barriers and lack

of interpretation services, fear of deportation, lack of mobility, lack of knowledge about U.S. systems, loss of interpersonal support systems, self-reliant attitudes, and discrimination and stigma (Beck et al., 2017, p. 34; Cabassa et al., 2006, p. 12; Hacker et al., 2015, p. 177).

Contrary to findings from existing literature, participants in this study did not reference suicidal ideation, borderline personality disorder, or bipolar disorder as major mental health concerns among the undocumented Latina population[6] (Perez & Fortuna, 2005, p. 116). While providers identified substance abuse among their migrant clients, none of the participants from the migrant interview group described experiencing or witnessing substance misuse. In my study, multiple providers emphasized that within Latino culture, alcohol is not considered a drug and substance abuse is not considered a mental health issue.

Another contrast between data from the literature review and that from key informant interviews was the impact of Latino gender roles on access to mental health care. While the existing literature largely indicates that undocumented migrant women may avoid seeking care for their documented children due to fears of deportation, women in my study expressed that their love for their children was the only thing that superseded their fear of the U.S. immigration system, with multiple participants stating that they rarely hesitated to seek care for their child when it seems necessary (Hacker et al., 2015, p. 8).

[6] It is important to note that even though participants did not disclose experiences with suicidal ideation, borderline personality disorder, or bipolar disorder, that does not mean these conditions are not present. It is possible that participants did not feel comfortable disclosing these concerns during their interview due to their severity, stigma, etc.

Implications of Findings

The results of this study have several implications, which range from small scale impacts on the day to day well-being of migrant women and their families, to hypotheses about what needs to change in the immigration and healthcare policy arenas. As explained in the literature review, policy in the U.S. is very dynamic; with each new presidential administration, we can expect a plethora of changes in regard to both healthcare provisions for the undocumented, and policy that either restricts or permits entry into the U.S. As such, it is essential that public health professionals – and the general public – have a comprehensive understanding of the history of this issue as well as the current state of the issue. My research aims to fill a gap in the literature: rather than investigate the behavioral health of this community from an outside perspective, this study centers on the experiences of the undocumented Latina migrant population. In addition, it aims to understand *why* and *how* existing behavioral health services struggle to provide for these women.

Limitations

In analyzing the research and developing recommendations, it became increasingly clear how interconnected the data points and broader issues were. Each idea and question brought up by a participant can be tied to another. Indeed, a key revelation from my research is that mental health care for undocumented Latina migrants is a complex tapestry, made up of the many interlocking parts discussed in this paper. As such, themes were extracted and categorized by their relevance to the research questions in order to best examine the data as parts and as a whole. That being said, this categorization is not intended to demonstrate mutual exclusivity, as each finding can be

tied to another. Because of the complexity of the issue of mental health care for undocumented Latina migrants and the time and resource constraints of my thesis, I was not able to fully investigate every aspect of the situation. If I had a chance to conduct this study for a second time, I would begin the interview process sooner, so I would have more time to examine the findings and their implications.

While my thesis investigates the experiences of undocumented Latina migrants in the Greater New Orleans area, it is important to note that this group is not homogenous and that these findings cannot necessarily be applied to undocumented populations in different cities or of different backgrounds. The importance of recognizing the uniqueness of each migrant individual is referenced throughout this thesis, particularly in discussions related to cultural lumping, but this matter should not be understated.

At the outset of the study, the methodology envisioned a minimum of 24 participants - 12 providers, and 12 migrants. As the research process progressed, however, it became apparent that these numbers would have to be adjusted due to a number of factors. Not only was securing interviews with the Latina migrant group difficult because of the sensitive nature of the topic, but the effects of saturation quickly set in. The diversity of information seemed to dwindle after a few interviews. In light of this – and the burden this research may put on subjects – pursuing further interviews with the migrant group was halted.

Recommendations for Reform

One of the main goals of this thesis was to draw on the research to inform recommendations for reform and advocacy towards improving the quality of and access to care for Latina migrants. What follows are key themes for change that emerged

through the research. This section identifies areas for suggested change at migrant-serving organizations, including: increasing language access and equity, lifting up Latino culture, and incorporating religion into service provision. Ultimately, the research points to multiple opportunities for systems change across the structures of organizations, from leadership to frontline providers. The diversity of the undocumented Latina migrant community should be at the center of this effort, which may require professionals in the field to unlearn certain things they have been taught and learn new things; and to try more vigorously to access the perspectives of the clients themselves.

Language Access and Equity

It is important for mental health professionals to encourage clients to speak in the language that feels comfortable to them – even if it is not the native language of the provider. Organizations should work to hold space and create resources in Spanish so that language accessibility is a norm rather than a specialized service. Migrant-serving organizations should consider adopting employment criteria that all staff who have direct contact with clients must be bilingual or working towards language proficiency. On a larger scale, the allocation of federal funding for interpretation services in healthcare clinics and emergency rooms would not only help to reduce the English-Spanish language barrier in service provision, but also increase the likelihood that any Spanish-speaking individual would seek out health services. Federal funding should also be used to support education and language acquisition on the provider side: government-funded programming to teach Spanish to mental health providers would be extremely beneficial to the functionality and quality of care organizations are able to provide to migrant clients.

Lift Up Latino Culture

While migrant-serving organizations should hire more bilingual or multilingual staff to work towards language equity for migrants, simply speaking Spanish is not enough. Recent national emphasis on diversity, equity and inclusion (DEI) may be doing some good in expanding culturally-competent care, but the research shows that even when an organization is staffed with an interpreter or another bilingual individual, this does not constitute the level of care needed to adequately address barriers in the mental healthcare system. A provider who has an understanding of Latino culture and/or the migration experience will make undocumented Latina migrants feel more comfortable speaking with them about mental health, which will in turn allow providers to establish trusting relationships with their clients and tailor services appropriately to each individual's unique needs. Some people simply may not want to use mental health care services, so providers should be trained in a delicate and culturally sensitive approach that enables them to share information about the benefits of these services without making potential clients feel pressured, or that care is being forced upon them.

Providers should also practice cultural humility and exhibit genuine curiosity about the lives of their clients, regardless of how similar or different their experiences may be. Non-Latino providers should be encouraged to learn about the history and culture of their clients, and work to understand each client's unique cultural and ethnic background. As noted in this thesis, the failure to embrace this kind of cultural and ethnic sensitivity may lead to cultural lumping, and to migrant service organizations becoming ineffective, transactional cogs in the country's larger immigration struggles.

Cultural Competency Through Respecting Religious Beliefs

It is also important that providers recognize and respect the religious beliefs of their clients – even if they pose challenges to the conventional delivery of care. Many undocumented Latina migrants practice a form of Catholicism with dogma that may impact their perception of mental health. For some Catholics, suffering is a major part of religion, which may lead them to steer away from seeking support for a mental health concern. Rather than trying to change the religious beliefs of the individual, providers should be educated in these belief systems, acknowledge the importance of faith, and develop skills in navigating their clients' religiosity – even making it a virtue in the process of delivering care. Faith can be an important and healthy coping mechanism for undocumented Latina migrants, so providers should learn to draw on the religion of their clients and use it as one of the tools in the mental health care arsenal.

Bolster Educational Initiatives

In the U.S., public health is a police power - meaning that it is largely administered through state and local authorities, not the federal government. As such, states should invest in education programs to teach undocumented women about navigating life in the United States. Unless those without legal documentation are taught how to access and utilize the many systems in the U.S., they will remain in the shadows; marginalized, ill-equipped to handle many situations, and ultimately at risk of many mental health ailments that will only further worsen their situation. The American public and the systems within it must stop viewing the undocumented Latina community as inherently bad, and instead focus on teaching them how to succeed in this country.

Organizations that provide case management and social services to undocumented Latina migrants should incorporate education into their service methodology, so that everyone who interacts with the organization is taught about sustaining a life for themselves and their families in the United States. Programmatic recommendations for education should include use of public transportation, technology like cell phones and computers, local options for health care and other social services, and accurate and simple information on immigration policy, etc. In addition, providers should be cognizant of their clients' personal preferences when it comes to communication. For instance, migrant participants in this study strongly preferred to speak over the phone rather than via email, Zoom, or by meeting face-to-face when talking about personal and mental health issues.

Address the Systemic Poverty of the Undocumented

Migration into the United States is not a phenomenon that will resolve itself without intentionality on the policy level. While the numbers may ebb and flow, immigration will never stop. Political, social, and economic beliefs aside, it is clear that the current immigration system is not functioning effectively. We must focus on policy reform that addresses the systemic marginalization, suffering, and exploitation of this population. The effort must look towards blunting the forces that sequester undocumented people into permanent positions of poverty.

Over one third of undocumented workers are paid below minimum wage, and close to 85% do not receive pay for working overtime, despite U.S. labor laws (Desmond, 2023). Undocumented migrants often feel they have no choice but to accept unlivable wages at taxing jobs. As such, policies that seek to raise minimum wages should (1)

enforce that wage across the undocumented population and (2) address the constantly rising cost of living in the U.S. For undocumented migrants who can barely make enough money to stay afloat, it is unsurprising that seeking out additional services to tend to their mental health is oftentimes not a top priority. We should lobby for policies that increase affordable housing around the U.S., particularly targeting options for Latina migrants and their families. If basic socioeconomic needs like affordable housing are not met, undocumented Latina migrants will continue to suffer from disproportionate and misunderstood mental illness. Mental health care in the United States is often seen as a luxury when it should be a fundamental right and essential component of every person's life – regardless of immigration status, level of income, race/ethnicity, etc.

Cross Border Collaboration

It is clear that the United States has much work to do domestically, but a holistic policy approach to the immigration situation in the U.S. must also look beyond our borders. Attention should be focused on the socioeconomic success of the countries from which migrants are fleeing. As mentioned, many participants said that their reason for illegally entering the U.S. was related to danger, crime, corruption, or violence and abuse in the country of origin. While the U.S. does not have authority over these countries, our foreign policy should recognize that our relations with them are integral to our own domestic health. This kind of view could translate into foreign aid, deeper cultural, social and educational ties, and even joint U.S.-Latin American public health well-being initiatives. If the U.S. can aid Latin American countries in strengthening the quality of life of their citizens, we might at the same time be able to tame politically-charged

arguments about keeping people out of our country, simply because there will be less desperation to come here in the first place.

Strengthen Connection Between Healthcare, Advocacy, and Reform

Armed with the knowledge that the undocumented Latina migrant community has unmet, misunderstood, and mistreated mental illness, health providers are capable of improving migrant mental health and equity in health access through advocacy, lobbying, and evaluation. Providers should collaborate with migrant-serving organizations and other agencies with social justice-oriented missions, to support organizational and governmental policies that would improve access to care for undocumented migrants.

Providers strongly recommended case management as a way to improve organizations' abilities to properly care for undocumented Latina migrants, indicating that migrant-serving organizations should create a case management division with multiple staff members, ideally Spanish-speaking, and fluent in Hispanic/Latino culture. Organizations that specifically function to provide legal or medical services to undocumented Latina migrants would especially benefit from case management for clients. Regardless of the success and commitment that an attorney has, an attorney alone cannot solve the other socioeconomic needs of that client – hence the importance of a case manager. A case manager handles the social services side of the client's needs, bringing them to doctors appointments, helping them fill out forms, using technology, and accessing public transportation. If agencies that primarily provide legal services also provide case management, the extra-curricular burden on legal professionals will be decreased, likely enhancing the quality of the defense they are able to provide to each client as a result.

At the federal level, an expansion of health insurance coverage and the healthcare safety net for the undocumented population are urgently needed. Future state and federal policies should also address, but not be limited to, increased funding for public programming, migrant-serving organizations, and community health centers. The impact of increased funding is evident. Though not widespread, in places where public health spending for the undocumented increased, care capacity also increased, sometimes dramatically. In San Francisco, for example, "converting former public health stations into full-spectrum primary care centers" with funding from the Department of Health vastly improved the quality and amount of care patients receive (Institute of Medicine Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers, 2000, p. 62).

Collaborate & Bring New Voices to the Table

A common misconception is that policy reform to benefit the undocumented creates a scenario where non-citizens are coddled with money from government agencies. This is a short-sighted outlook on a public health matter that ripples from the shores of the undocumented community throughout the rest of society. We cannot truly be healthy when a large and influential part of our society is not. In other words, the health of the Latina migrant community is not an isolated concern; it is one that impacts us all in numerous ways and should be recognized that way.

With this public health philosophy in mind, a collective approach to the problem is essential. Stakeholders from various positions must collaborate to educate one another, welcome new voices to the table – most importantly, members of the Latina community – and move towards solutions and away from misinformation and divisiveness. Rather than

making assumptions, based on stereotypes or existing information, about the mental health needs of undocumented Latina migrants, curious individuals and organizations should conduct their own research and make space for their own conversations about the issue. Contributing new research and perspectives to issues facing this community, while facilitating the involvement of those directly impacted by the issue in professional settings, especially in leadership and advocacy positions, is one of the best change-making strategies in this arena.

CHAPTER SEVEN: CONCLUSION

These are the people who couldn't go to school because their parents were scared of ICE, the people who lived in a violent environment, or the people that someone told, "You are dumb! You won't be able to get into college." These are the people who went to the streets and started getting drugs and smoking and ended up in jail or detained. Now, this person is a 30-year-old woman and she came to us and told us,"Nobody gave me the opportunity," and we said to her, "You can do it – we know that you can do it. You will get that opportunity because you are going to open up the doors to your own opportunity." So that's what we need. We need to start believing in us, believing in our people. We tell our students, "You are going to speak the language! You are going to be bilingual!" – Provider interview

This thesis aimed to investigate the interactions between undocumented Latina migrants and the U.S. mental health care system through the perspectives of those directly involved in the issue: providers at migrant-serving organizations and the undocumented women themselves. In order to do so, I conducted 18 key informant interviews (12 with providers and 6 with undocumented Latina migrants) which were complemented and contrasted by information gathered through an extensive literature and policy review. Four primary research questions underscored these qualitative methods:

1) What are the behavioral health needs of undocumented Latina migrants and why are these conditions or needs present?
2) What behavioral health services are available to undocumented Latina migrants in the Greater New Orleans area?
3) What are the perceived impediments to accessing care – from the perspectives of both the migrants and the providers?
4) What policy reform and advocacy work can be done to better the system and improve access for vulnerable individuals, specifically undocumented Latina migrants?

Previous work and experience in the field led me to hypothesize that services for undocumented Latina migrants could not meet their unique behavioral health needs. I attributed this to an overarching concept: that anti-immigrant narratives in the U.S. led migrants to be disenfranchised from mental healthcare related systems. My findings illustrated that while anti-immigrant narratives do contribute to the inadequate behavioral health services for undocumented Latina migrants, a plethora of other interrelated factors also play a large role.

This study has led me to the conclusion that one of the cornerstone issues between the behavioral health system and undocumented Latina migrants is the lack of true cultural competency in service provision. Latino culture is unique and different in many ways from American norms. Unless this difference is fully embraced and accounted for, it is unlikely that Latina women will feel comfortable accessing care, or that services for this population will have a long-lasting impact. Furthermore, I found that many of the behavioral health needs of this population are exacerbated by and intertwined with their experiences as migrants and as non-citizens. The stigmatization, discrimination, isolation, trauma, and abuse that the undocumented Latina migrant community endures are causal factors in their poor mental health outcomes. Another compounding factor is that while there are attempts being made to diagnose and treat Latina migrants, many are unaware of their mental health conditions and do not view medical care according to conventional American standards.

After synthesizing the research, I came away with five key recommendations for improving the quality of and access to care for Latina migrants:

1) Improving language access: Organizations must work to provide accessible language services that are reliable, culturally sensitive, and linguistically competent. This could include hiring bilingual staff or interpreters and ensuring that all materials, including consent forms and medical information, are available in Spanish.
2) Lifting up Latino culture: To address cultural lumping and better serve the diverse needs of Latina migrants, organizations should prioritize understanding and celebrating Latino culture. This can be achieved through hiring more Latino staff and providing cultural competency training to all employees.
3) Incorporating religion into service provision: For some Latina migrants, religion is an important part of their cultural and personal identity. Organizations should explore ways to incorporate religious practices or affiliations into service provision in a respectful and non-coercive way.
4) Prioritizing the needs of the community: Organizations must work to center the needs of the undocumented Latina migrant community in all decision-making processes. This could include actively seeking out and incorporating feedback from patients and community members and developing services that are tailored to their unique needs and experiences.
5) Advocating for policy change: Organizations and providers must advocate for policy change at the local, state, and national levels to improve access to care for undocumented Latina migrants. This could include advocating for policies that expand access to health care and mental health services, increase funding for

language access services, and address systemic issues that contribute to health disparities.

For some of us, the issue of healthcare access for the undocumented may feel so far removed that it is hard to conceptualize next steps or the urgency of the situation.But with this thesis, I have tried to contribute to a broad call to action for the health of not only the undocumented population, but of our nation as a whole. The issue couldn't be more urgent or timely. As I write in the spring of 2023, accounts of a horrifying mass death of at least 40 migrants in a fire at a detention center plague the news (Verza & Lee, 2023). Collective ongoing trauma of the migration experience could get worse still, with new reports indicating that the U.S. is considering reinstating the detention and separation of migrant families at the border – a policy that the Biden administration slashed early in his presidency, citing desire for a more humane immigration system (Sullivan & Kanno-Youngs, 2023). Family separation was cited in this study as one of the most common causes of trauma leading to poor mental health outcomes among participants, yet it could become policy again as early as May 2023. The time is now to act on behalf of undocumented women and their families, relegated to the shadows time and time again. Our nation must come together to protect the basic human needs of the most vulnerable, through efforts big and small.

References

Beck, T. L., Le, T., Henry-Okafor, Q., & Shah, M. K. (2017). Medical Care for Undocumented Immigrants. *Primary Care: Clinics in Office Practice, 44*(1). doi:10.1016/j.pop.2016.09.005

Cabassa, L. J., Zayas, L. H., & Hansen, M. C. (2006). Latino Adults' Access to Mental Health Care: A Review of Epidemiological Studies. *Administration and Policy in Mental Health and Mental Health Services Research, 33*(3), 316-330. doi:10.1007/s10488-006-0040-8

Centers for Disease Control and Prevention. (2022, March 12). *Title 42 Termination with Respect to Unaccompanied Noncitizen Children* [Press release]. https://www.cdc.gov/media/releases/2022/s0311-title-42-termination.html

Chau, V. (2020). The Opioid Crisis and the Hispanic/Latino Population: An Urgent Issue. Retrieved April 7, 2022, from https://store.samhsa.gov/product/The-Opioid-Crisis-and-the-Hispanic-Latino-Population-An-Urgent-Issue/PEP20-05-02-002

Cobb, C. L., Xie, D., Meca, A., & Schwartz, S. J. (2017, April 1). Acculturation, discrimination, and depression among unauthorized Latinos/as in the United States. *Cultural Diversity and Ethnic Minority Psychology, 23*(2), 258-268. doi:10.1037/cdp0000118

Cohn, D. (2015, September 30). *How U.S. Immigration Laws and Rules Have Changed Through History*. Pew Research Center. Retrieved February 21, 2021, from http://www.pewresearch.org/fact-tank/2015/09/30/how-u-s-immigration-laws-and-rules-have-changed-through-history/.

Comorbidity: Substance Use Disorders and Other Mental Illnesses Drug Facts. (2021, August 03). Retrieved April 6, 2022, from https://nida.nih.gov/publications/drugfacts/comorbidity-substance-use-disorders-other-mental-illnesses

Creamer, J. (2021, December 09). Inequalities Persist Despite Decline in Poverty for All Major Race and Hispanic Origin Groups. https://www.census.gov/library/stories/2020/09/poverty-rates-for-blacks-and-hispanics-reached-historic-lows-in-2019.html

Desmond, M. (2023, March 9). Why Poverty Persists in America. *The New York Times*. https://www.nytimes.com/2023/03/09/magazine/poverty-by-america-matthew-desmond.html?login=email&auth=login-email

Dillon, F. R., Rosa, M. D., Sanchez, M., & Schwartz, S. J. (2012). Pre Immigration family cohesion and drug/alcohol abuse among recent Latino immigrants. *The Family Journal, 20*(3), 256-266. doi:10.1177/1066480712448860

Edwards, J. A., & Herder, R. (2012). Melding a New Immigration Narrative: President George W. Bush and the Immigration Debate. *The Howard Journal of Communications*, *23*, 40-65. 10.1080/10646175.2012.64187840

Edward, J. (2014). Undocumented Immigrants and Access to Health Care: Making a Case for Policy Reform. *Policy, Politics, & Nursing Practice, 15*(1-2), 5-14. doi:10.1177/1527154414532694

Enchautegui, M. E. (2016, March 25). *Immigrant and Native Workers Compete for Different Low-Skilled Jobs*. Urban Wire. http://www.urban.org/urban-wire/immigrant-and-native-workers-compete-different-low-skilled-jobs.

Ettinger, P. (2009). *Imaginary Lines: Border Enforcement and the Origins of Undocumented Immigration, 1882-1930* (1st ed.). University of Texas Press.

Fortuna, L. R., Porche, M. V., & Alegria, M. (2008). Political Violence, Psychosocial Trauma, and the Context of Mental Health Services Use Among Immigrant Latinos in the United States. *Ethnicity & Health, 13*(5), 435-463. doi:10.1080/13557850701837286

Friedberg, M. W., Hussey, P. S., & Schneider, E. C. (2010, May). Primary Care: A Critical Review Of The Evidence On Quality And Costs Of Health Care. *Health Affairs*, *29*(5), 766-772. https://doi.org/10.1377/hlthaff.2010.0025

Garcini, L. M., Chen, M. A., Brown, R. L., Galvan, T., Saucedo, L., Berger Cardoso, J. A., & Fagundes, C. P. (2018, November 1). Kicks Hurt Less: Discrimination Predicts Distress Beyond Trauma Among Undocumented Mexican Immigrants. *Psychology of Violence, 8*(6), 692-701. doi:10.1037/vio0000205

Garcini, L. M., Peña, J. M., Galvan, T., Fagundes, C. P., Malcarne, V., & Klonoff, E. A. (2017). Mental Disorders Among Undocumented Mexican Immigrants in High-Risk Neighborhoods: Prevalence, Comorbidity, and Vulnerabilities. *Journal of Consulting and Clinical Psychology, 85*(10), 927-936. doi:10.1037/ccp0000237

Garrity, K. (2022, September 8). *DHS Unwinds Trump-Era 'Public Charge' Rule for Immigrants*. Politico. Retrieved November 4, 2022, from https://www.politico.com/news/2022/09/08/trump-public-charge-rule-immigrants-biden-00055505

González, M. J., & González-Ramos, G. (2011). *Mental Health Care for New Hispanic Immigrants: Innovative Approaches in Contemporary Clinical Practice*. New York, New York: Routledge. ISBN: 9780789023087

Gramlich, J. (2022, April 27). *Key Facts About Title 42, the Pandemic Policy that Has Reshaped Immigration Enforcement at U.S.-Mexico Border*. Pew Research Center. https://www.pewresearch.org/fact-tank/2022/04/27/key-facts-about-title-42-the-pandemic-policy-that-has-reshaped-immigration-enforcement-at-u-s-mexico-border/

Hazen, A. L., & Soriano, F. I. (2007). Experiences with Intimate Partner Violence Among Latina Women. *Violence Against Women, 13*(6), 562-582. doi:10.1177/1077801207301558

Hacker, K., Anies, M., Folb, B. L., & Zallman, L. (2015). Barriers to Health Care for Undocumented Immigrants: A Literature Review. *Risk Management and Healthcare Policy*, *8*, 175–183. https://doi.org/10.2147/RMHP.S70173

Hackman, M. (2023, January 9). *What Is Title 42? What It Means for Immigration and the U.S.-Mexico Border*. Wall Street Journal. https://www.wsj.com/articles/what-is-title-42-border-rules-migration-1164911853 9

Health Coverage of Immigrants. (2022, April 6). KFF. Retrieved November 4, 2022, from https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/.

Holliday-Moore, R., & Chau, V. (2019, October 15). Opioid and Illicit Drug Use Among the Hispanic/Latino Populations. Retrieved April 5, 2022, from https://www.samhsa.gov/blog/opioid-illicit-drug-use-among-hispaniclatino-populations#:~:text=SAMHSA%27s%20National%20Survey%20on%20Drug,opioids%20in%20the%20past%20year.

Kanno-Youngs, Z., & Sullivan, E. (2023, March 6). U.S. Is Said to Consider Reinstating Detention of Migrant Families. *The New York Times*. https://www.nytimes.com/2023/03/06/us/politics/biden-immigration-family-detention.html?fbclid=IwAR1taD7E09cYB4IYhF9FL3nCSBi3LalbBkjiiUwbVNuLaZNoaxNPogP7q4w

Lalander, P. (2003). *Hooked on Heroin: Drugs and Drifters in a Globalized World*. New York, New York: Oxford International.

Law Enforcement Immigration Task Force. (2021). *Comparison of the Obama, Trump, and Biden Administration Immigration Enforcement Priorities*. Law Enforcement Immigration Task Force. https://leitf.org/wp-content/uploads/2021/04/Enforcement-Priorities-Memo.pdf

Lewin, M. E., & Altman, S. (2000). *America's Health Care Safety Net: Intact but Endangered*. Washington, DC: National Academies Press. doi:10.17226/9612

Maschi, T., Bradley, C., & Ward, K. (2009). *Forensic Social Work: Psychosocial and Legal Issues in Diverse Practice Settings*. New York, New York: Springer Publishing Company. ISBN: 978-0-8261-1858-5

McCarthy, A., & Coleborne, C. (2012). *Migration, Ethnicity, and Mental Health: International Perspectives, 1840-2010*. New York, New York: Routledge. ISBN: 9781138378056

Moya, E. M., & Shedlin, M. G. (2008). Policies and Laws Affecting Mexican-Origin Immigrant Access and Utilization of Substance Abuse Treatment: Obstacles to Recovery and Immigrant Health. *Substance Use & Misuse, 43*(12-13), 1747-1769. doi:10.1080/10826080802297294

National Hispanic and Latino Mental Health Technology Transfer Center. (2022). *The Experience of Being a Non-Latino Mental Health Professional Who Works with Latinx Clients: Providing Appropriate Transcultural Care.* https://mhttcnetwork.org/sites/mhttc/files/2023-01/Non-Latino%20Professional%20with%20Latinx%20Client%20Booklet%20V3.pdf

Nuñez, A., González, P., Talavera, G. A., Sanchez-Johnsen, L., Roesch, S. C., Davis, S. M., Arguelles, W., Womack, V. Y., Ostrovsky, N. W., Ojeda, L., Penedo, F. J., & Gallo, L. C. (2016). Machismo, Marianismo, and Negative Cognitive-Emotional Factors: Findings From the Hispanic Community Health Study/Study of Latinos Sociocultural Ancillary Study. *Journal of Latina/o Psychology*, *4*(4), 202–217. https://doi.org/10.1037/lat0000050.

O'Brien, B. C., Harris, I. B., Beckman, T. J., Reed, D. A., & Cook, D. A. (2014, September). Standards for Reporting Qualitative Research: A Synthesis of Recommendations. *Academic Medicine*, *89*(9), 1245-1251. doi: 10.1097/ACM.0000000000000388

O'Connor, A., Batalova, J., & Bolter, J. (2019, August 15). Central American Immigrants in the United States. *The Online Journal of the Migration Policy Institute*. https://www.migrationpolicy.org/article/central-american-immigrants-united-states-2017

Ornelas, I. J., & Perreira, K. M. (2011, October). The Role of Migration in the Development of Depressive Symptoms among Latino Immigrant Parents in the USA. *Social Science & Medicine*, *73*(8), 1169-1177. doi:10.1016/j.socscimed.2011.07.002.

Otiniano Verissimo, A. D., Gee, G. C., Iguchi, M. Y., Ford, C. L., & Friedman, S. R. (2013). Discrimination, Drugs, and Alcohol Among Latina/os in Brooklyn, New York: Differences by Gender. *International Journal of Drug Policy, 24*(4), 367-373. doi:10.1016/j.drugpo.2013.01.010

Pagano, A. (2014). Barriers to Drug Abuse Treatment for Latino Migrants: Treatment Providers' Perspectives. *Journal of Ethnicity in Substance Abuse, 13*(3), 273-287. doi:10.1080/15332640.2014.886320

Parrillo, V. N. (2008). Drug Abuse. In *Encyclopedia of Social Problems* (Vol. 1, pp. 255-258). Thousand Oaks: SAGE Publications.

Passel, J. S. (2005). Unauthorized Migrants: Numbers and Characteristics. *Pew Hispanic Center*, 1–44. Retrieved April 26, 2023, from https://www.pewresearch.org/wp-content/uploads/sites/5/reports/46.pdf.

Passel, J. S., & Cohn, D. (2018, November 27). U.S. Unauthorized Immigrant Total Dips to Lowest Level in a Decade. *Pew Research Center*. https://www.pewresearch.org/hispanic/wp-content/uploads/sites/5/2019/03/Pew-Research-Center_2018-11-27_U-S-Unauthorized-Immigrants-Total-Dips_Updated-2019-06-25.pdf

Pérez, M. C., & Fortuna, L. (2013). Psychosocial Stressors, Psychiatric Diagnoses and Utilization of Mental Health Services Among Undocumented Immigrant Latinos.

Mental Health Care for New Hispanic Immigrants, 107-124. doi:10.4324/9780203725634-6

Remain in Mexico': Overview and Resources. (2022, February 7). Human Rights Watch. https://www.hrw.org/news/2022/02/07/remain-mexico-overview-and-resources

Sher, L., & Vilens, A. (2011). *Immigration and Mental Health: Stress, Psychiatric Disorders and Suicidal Behavior Among Immigrants and Refugees*. Hauppauge, NY: Nova Science.

Strathdee, S. A., Philbin, M. M., Semple, S. J., Pu, M., Orozovich, P., Martinez, G., . . . Patterson, T. L. (2008). Correlates of Injection Drug Use Among Female Sex Workers in Two Mexico–U.S. Border Cities. *Drug and Alcohol Dependence, 92*(1-3), 132-140. doi:10.1016/j.drugalcdep.2007.07.001

Temporary Protected Status (TPS). (2021, March 12). National Immigration Forum. https://immigrationforum.org/wp-content/uploads/2021/03/TPS-Fact-Sheet_Final-March-12-2021.pdf

Trump, D. (2015, June 16). *Here's Donald Trump's Presidential Announcement Speech*. TIME. https://time.com/3923128/donald-trump-announcement-speech/.

Vargas, R. A., & Adelso, J. (2022, January 2). *'We're somewhere familiar': Jefferson's Hispanic population drives Louisiana's growth*. Nola.com. https://www.nola.com/news/were-somewhere-familiar-jeffersons-hispanic-population-drives-louisianas-growth/article_2304af7c-5f87-11ec-b2a4-cf1feb4fddf8.html

Verza, M., & Lee, M. (2023, March 28). Video shows guards walking away during fire that killed 38. *Associated Press News*. https://apnews.com/article/mexico-fire-migrant-facility-dead-eea0b6efafd77f9868ef27ed1cf572b3

Wolgin, P. E. (2014, October 6). *By the Numbers: Every President Since Eisenhower Has Taken Executive Action on Immigration*. Center for American Progress. Retrieved January 22, 2023, from

Mental Health Care for New Hispanic Immigrants, 107-124. doi:10.4324/9780203725634-6

Remain in Mexico': Overview and Resources. (2022, February 7). Human Rights Watch. https://www.hrw.org/news/2022/02/07/remain-mexico-overview-and-resources

Sher, L., & Vilens, A. (2011). *Immigration and Mental Health: Stress, Psychiatric Disorders and Suicidal Behavior Among Immigrants and Refugees*. Hauppauge, NY: Nova Science.

Strathdee, S. A., Philbin, M. M., Semple, S. J., Pu, M., Orozovich, P., Martinez, G., . . . Patterson, T. L. (2008). Correlates of Injection Drug Use Among Female Sex Workers in Two Mexico–U.S. Border Cities. *Drug and Alcohol Dependence, 92*(1-3), 132-140. doi:10.1016/j.drugalcdep.2007.07.001

Temporary Protected Status (TPS). (2021, March 12). National Immigration Forum. https://immigrationforum.org/wp-content/uploads/2021/03/TPS-Fact-Sheet_Final-March-12-2021.pdf

Trump, D. (2015, June 16). *Here's Donald Trump's Presidential Announcement Speech*. TIME. https://time.com/3923128/donald-trump-announcement-speech/.

Vargas, R. A., & Adelso, J. (2022, January 2). *'We're somewhere familiar': Jefferson's Hispanic population drives Louisiana's growth*. Nola.com. https://www.nola.com/news/were-somewhere-familiar-jeffersons-hispanic-population-drives-louisianas-growth/article_2304af7c-5f87-11ec-b2a4-cf1feb4fddf8.html

Verza, M., & Lee, M. (2023, March 28). Video shows guards walking away during fire that killed 38. *Associated Press News*. https://apnews.com/article/mexico-fire-migrant-facility-dead-eea0b6efafd77f9868ef27ed1cf572b3

Wolgin, P. E. (2014, October 6). *By the Numbers: Every President Since Eisenhower Has Taken Executive Action on Immigration*. Center for American Progress. Retrieved January 22, 2023, from

https://www.americanprogress.org/article/by-the-numbers-every-president-since-eisenhower-has-taken-executive-action-on-immigration/

Yu, M., Kelley, A. T., Morgan, A. U., Duong, A., Mahajan, A., & Gipson, J. D. (2020). Challenges for Adult Undocumented Immigrants in Accessing Primary Care: A Qualitative Study of Health Care Workers in Los Angeles County. *Health Equity, 4*(1), 366-374. doi:10.1089/heq.2020.0036

APPENDIX A: IRB APPROVAL CERTIFICATE

Tulane Human Research Protection Office
Institutional Review Boards
Biomedical
Social Behavioral
FWA00002055

DATE: September 29, 2022

TO: Lydia Garrett-Metz
FROM: Tulane University Social-Behavioral IRB

STUDY TITLE: Wall after Wall: Mental Healthcare for Undocumented Latina Migrants

REF #: 2022-1155
SUBMISSION TYPE: Initial Submission

ACTION: **APPROVED**

On September 29, 2022, the Tulane University Social-Behavioral IRB provided an expedited review and approval determination for the initial submission of this minimal risk study. The review was provided in accordance with the appropriate research regulations.

The following items were submitted as part of the submission:

- Interview Guide - ENGLISH.docx (Interview Script)
- Certificate of Translation 1 (Other)
- Certificate of Translation 2 (Other)
- Informed Consent Form - ENGLISH.docx (Other Recruitment Material)
- Informed Consent Form - ENGLISH.docx (Consent Form (Social Behavioral))
- Informed Consent Form - SPANISH.docx (Consent Form (Social Behavioral))

- Informed Consent Form - SPANISH.pdf (Consent Form (Social Behavioral))
- Interview Guide - SPANISH.docx (Questionnaires/Surveys)
- Interview Guide - SPANISH.docx (Interview Script)
- Program Believe Letter of Support (Letter of Support)
- Provider Recruitment Email.pdf (Recruitment Letter)
- Thesis Research Protocol.pdf (Study Protocol)

This study is approved for the local enrollment of 28 subjects.
This study is granted an approval period of September 29, 2022 - September 28, 2023.

The Tulane University IRB approved and stamped informed consent and/or assent form(s) must be used when enrolling subjects.

All research must be conducted in accordance with this approved submission.

Please submit any proposed changes to the research study, including enrollment of additional study participants, to the IRB for review and approval prior to implementation, unless a change is necessary to avoid immediate harm to subjects. If subject safety becomes an issue, please notify Tulane University Human Research Protection Office (HRPO) as soon as possible.

The informed consent process begins with a description of the study and assurance of participant understanding followed by a signed consent form. Informed consent must continue throughout the study with dialogue between the Investigator and research participant. Federal regulations require each participant to receive a copy of their signed consent form unless the IRB waives this requirement.

Please submit any unanticipated problems involving risk to subjects or others, deviations from the approved research, non-compliance, and complaints to the IRB in accordance with Tulane University Human Research Protection Program (HRPP) Standard Operating Procedures (SOPs). Please contact the HRPO via irbmain@tulane.edu or (504) 988-2665 if you have questions and/or concerns regarding reporting events. In addition, please also submit any reports generated by the DSMB or oversight committee to the IRB, if required.

Federal Regulation 45 CFR 46.109(e) states that an IRB must conduct a continuing review of research at intervals appropriate to the degree of risk, but not less than one year. The federal regulations provide no grace period. Failure to obtain approval for continuation of this study prior to the expiration date will require discontinuation of all research activities, including enrollment of new subjects. Per Federal Regulations and Tulane HRPP policy, this study will be administratively closed 30 days after the expiration date, if approval for continuation of this study has not been granted.

If your study is supported in whole or in part by a federal grant, please note that Federal regulations prohibit the use of Federal funds for human subject research that is not conducted under current IRB approval. Loss of IRB approval for this study due to lapse, suspension or termination will be communicated by the Tulane IRB to Tulane's Office of Grants and Contracts Accounting, which may result in an administrative hold being placed on the related grant(s). Therefore, to avoid an interruption in research activity, including use of coded, identifiable human data or biospecimens, and access to grant funds it is critical that IRB approval for the study be maintained.

Please notify the IRB within 30 days of completion of all study activities and data analysis by submitting a Study Closure Form.

The Principal Investigator is responsible for being familiar with and complying with Tulane University HRPP SOPs found at https://research.tulane.edu/hrpo. Please do not hesitate to contact our office with any questions or concerns.

We encourage investigators and research staff to provide feedback about the IRB review process, our website, and any other aspects of the HRPP that will help us to identify improvements we can make. You can complete this form in an anonymous manner at HRPO/IRB Feedback Survey.

Sincerely,

Tulane University Human Research Protection Office
Please note that the actual signature by the IRB Chair(s) is not required for this document to be effective. IRBManager generates this letter pursuant to the IRB Chair's electronic signature and approval. This process is consistent with Federal Regulations and Tulane Standard Operating Policies with respect to the IRB and Human Research Protection Office, which consider electronically generated documents as official notices to sponsors and others of approval, disapproval or other IRB decisions. Please refer to Tulane's Electronic Signatures and Records Policy by visiting the HRPO website at https://research.tulane.edu/hrpo.

APPENDIX B: INTERVIEW GUIDE – ENGLISH

Interview Questions

Undocumented Latina Migrants

Personal Narrative

Intro Question: I'd like to start by having you share your age, where you are from, and what race/ethnicity you identify as.

1. What were the conditions and circumstances that caused you to leave where you were prior to coming to the U.S.?
2. What has it been like for you since arriving in the U.S.?
    a. What, if any, are the main problems and challenges you face now?

Mental Health

3. What does the phrase "mental health" mean to you?
4. Is mental health a subject you thought about/dealt with before coming to the U.S.?
5. How would you describe your own mental health?
    a. What mental health issues, if any, have you struggled with?
    b. When did you first notice or begin to struggle with these issues?

Drug Use & Violence

6. I know that substance use and abuse are a problem in many communities, can you talk about if this has been a problem in your own life, family, or community?
7. Emotional or physical violence threatens the health and lives of many women. If you are comfortable sharing, can you talk about any experience you may have had with this?

Experiences with Care

8. Tell me about how comfortable you are/would be discussing your mental health issues with your family or members of your community.
    a. Did you receive support or was there any stigma in your community or family about mental health issues?
9. How did you get help for your mental health needs?
    a. Explain the process you went through to access mental healthcare.
    b. Explain the treatment process that you went through after your initial interaction with the healthcare provider/facility.

Impediments and Problems with Care

10. What problems, if any, did you face while trying to access mental health care in the U.S.?
11. What worked, if anything, while you were trying to access/accessing mental healthcare?

Suggestions for Improvement / Needs

12. What would you like to see change about the mental healthcare system in the US?
    a. What changes would have made your experience more positive?

Closing Question: Is there anything else you would like to share with me today that we have not already discussed?

Service Providers

Professional Narrative

Intro Question: I'd like to start by having you share where you are from, what race/ethnicity you identify as, and what you do (title, role, organization).

- *Do you have a particular area of expertise/specialty?*
- *How long have you been doing this work? How did you get into this field?*

1. Are you or your organization private, non-profit, affiliated with or subsidized by the government? Do you or your organization have religious or other affiliations?
    a. How do these factors influence, if at all, the services you provide?

Clientele

2. Who are your clientele (ages, gender, country of origin, documented v. undocumented)?
    a. *What percentage are undocumented Latinas, if any?*
3. Can you describe some of the key mental health issues that your clients face?
    a. *How big a factor is immigration status?*
    b. *How big a factor is substance use/abuse?*
    c. *How big a factor is domestic violence/IPV?*
4. Are there themes or commonalities when it comes to traumas faced by these women?
5. How do they generally find you? How do they access your services?
    a. *Referrals? Community outreach? Medical or legal system?*

Methodology/Services

6. Can you describe your approach to providing services to your clients?
    a. Is it in groups, one-on-one?

   b. *Is it conducted in English or Spanish?*
   c. *Is your approach targeted to the individual or does it encompass families as well?*
7. What is the financial process - is there any cost?
8. How do you deal with issues of substance abuse, domestic violence or other traumas that might require medical or legal intervention?
9. What differences exist between how you approach treating this population and how one might serve the general public?

<u>Challenges/Successes</u>

10. What do you see as the most significant challenges these women face in getting care?
11. What do you see as your greatest challenges in providing care?

<u>Suggestions for Improvement/Needs</u>

12. Can you talk about what you think the most pressing needs are for improving service to this population?
13. Does change need to happen in the private/non profit sector or from the government? Both?
    a. If the government should be involved, how do you see this happening? Are there any policies that need changing or should new policies be enacted?

Closing Question: Is there anything else you would like to share with me today that we have not already discussed?

APPENDIX C: INTERVIEW GUIDE – SPANISH

Entrevista Preguntas

Migrantes Latinas Indocumentadas:

Narración Personal

Pregunta de introducción: Me gustaría empezar por que compartas tu edad, de dónde proviene y con qué raza/etnica te identificas.

1. ¿Cuáles fueron las condiciones y circunstancias que le llevaron a salir del lugar en el que se encontraba antes de llegar a EE. UU.?
2. ¿Cómo ha sido para usted desde que llegó a los EE.UU.?
    a. ¿Cuáles son, si los hay, los principales problemas y desafíos a los que se enfrenta ahora?

Salud Mental

1. ¿Qué significa para usted la frase "salud mental"?
2. ¿Es la salud mental un tema sobre el que pensó o trató antes de venir a los Estados Unidos?
3. ¿Cómo describiría su propia salud mental?
    a. ¿Con qué problemas de salud mental, si los hay, ha luchado?
    b. ¿Cuándo notó por primera vez estos problemas o comenzó a afrontarlos?

Uso de Drogas y Violencia

4. Sé que el uso y el abuso de sustancias son un problema en muchas comunidades, ¿puede usted hablar de si esto ha sido un problema en su propia vida, familia o comunidad?
5. La violencia emocional o física amenaza la salud y la vida de muchas mujeres. Si se siente cómodo compartiendo, ¿puede hablar de cualquier experiencia que haya tenido con esto?

Experiencias con la Atención

6. Háblame de lo cómodo que se siente/estaría discutiendo sus problemas de salud mental con su familia o miembros de su comunidad.
    a. ¿Recibió apoyo o hubo algún estigma en su comunidad o familia acerca de los problemas de salud mental?
7. ¿Cómo obtuvo ayuda para sus necesidades de salud mental?
    a. Explique el proceso por el que pasó para acceder a la atención médica mental.

b. Explique el proceso de tratamiento por el que pasó después de su interacción inicial con el proveedor/centro sanitario.

Problemas con la Atención

8. ¿Qué problemas, si los hubiera, enfrentó mientras trataba de tener acceso a la atención de salud mental en los Estados Unidos?
9. ¿Qué funcionó, si acaso, mientras intentaba acceder a la atención médica mental o acceder a ella?

Sugerencias para Mejorar/Necesidades

10. ¿Qué cambios le gustaría ver en el sistema de salud mental en Estados Unidos?
    a. ¿Qué cambios podrian haber hecho para que su experiencia fuera más positiva?

Pregunta final: ¿Hay algo más que le gustaría compartir conmigo hoy que aún no hemos tratado?

Proveedores de Servicios

Narrativa Profesional

Pregunta de introducción: Me gustaría empezar por compartir su edad, de dónde proviene, con qué raza o etnia se identifica y qué hace (cargo, organización).

- *¿Tiene un área de especialización o especialidad en particular? ¿Cuánto tiempo lleva haciendo este trabajo?*
- *¿Cómo entró en este campo?*

1. ¿Es usted o su organización privada, sin fines de lucro, afiliada o subsidiada por el gobierno? ¿Tiene usted o su organización afiliaciones religiosas o de otro tipo?
    a. ¿Cómo influyen estos factores, si es que lo hacen, en los servicios que presta?

Los Clientes

2. ¿Quiénes son sus clientes (edades, género, país de origen, documentado ó indocumentado)?
    a. ¿Qué porcentaje son Latinas indocumentadas, si las hay?
3. ¿Puede describir algunos de los problemas clave de salud mental que enfrentan sus clientes?
    a. ¿Cuál es el factor de la situación migratoria?
    b. ¿Cuál es el factor de consumo/abuso de sustancias?

    c. ¿Cuál es el factor de violencia doméstica/IPV?
4. ¿Hay temas o puntos en común cuando se trata de traumas a los que se enfrentan estas mujeres?
5. ¿Cómo suelen encontrarle? ¿Cómo acceden a sus servicios?
    a. ¿Referencias? ¿Alcance comunitario? Sistema médico o legal?

Metodología/Servicios

6. ¿Puede describir su enfoque para prestar servicios a sus clientes?
    a. ¿Se trata de grupos, uno a uno?
    b. ¿Se realiza en inglés o en español?
    c. ¿Su enfoque está dirigido al individuo o abarca también a las familias?
7. ¿Cuál es el proceso financiero? ¿Hay algún costo?
8. ¿Cómo se ocupa de los problemas de abuso de sustancias, violencia doméstica u otros traumas que podrían requerir intervención médica o legal?
9. ¿Qué diferencias existen entre cómo aborda el tratamiento de esta población y cómo se podría servir al público en general?

Desafíos/Éxitos

10. ¿Cuáles considera que son los desafíos más importantes que enfrentan estas mujeres para obtener atención?
11. ¿Cuáles considera que son sus mayores desafíos en la prestación de atención?

Sugerencias para Mejorar/Necesidades

12. ¿Puede hablar sobre cuáles cree que son las necesidades más importantes para mejorar el servicio a esta población?
13. ¿Es necesario que el cambio se produzca en el sector privado/sin fines de lucro o desde el gobierno? ¿Ambas?
    a. Si el gobierno debe participar, ¿cómo ve que esto sucede? ¿Hay políticas que necesiten cambiar o deben promulgarse nuevas políticas?

Pregunta final:¿Hay algo más que le gustaría compartir conmigo hoy que aún no hemos tratado?

APPENDIX D: INFORMED CONSENT FORM – ENGLISH

Tulane University Human Research Protection Office
Social/Behavioral IRB
Consent Form for Participation in a Research Study
Wall After Wall: Mental Healthcare for Undocumented Latina Migrants

Research Consent Form

Study Title: Wall after Wall: Mental Healthcare for Undocumented Latina Migrants
Study Site: Tulane University
Study Site Investigator (Researcher): Lydia Garrett-Metz
Faculty Advisor: Eva Silvestre

Summary

Research is not treatment:

You may be eligible to participate in a research study. Research is not treatment. The purpose of this research is to understand the behavioral health needs of undocumented Latina migrants in the U.S., from the perspective of the women themselves, as well as those who provide services. The study is examining how the mental healthcare system works and doesn't work for this population, and what can be done to improve access and care.

Whether you participate in research is up to you:

It is your choice (1) whether to find out if you are eligible to participate in the study, and if so, (2) whether to participate. If you decide to participate, you can stop participating at any time. If you do not participate, or if you participate but later stop, you will not lose any of your regular benefits and you can still get care if you need it.

If you participate, it will involve the following:

Participation in this study involves a 30-60 minute interview to discuss your experiences with and knowledge of this topic. Interviews will take place in-person or via Zoom and will be audio and/or video recorded, with your consent. Interviews do not have to be recorded; you can also participate in an interview without recording.

Participation comes with some risks that you should consider carefully:

Participation in this study may expose you to these common risks or discomforts: some topics that could be of sensitive nature may come in during interviews.

Risks for this study are considered to be minimal; despite the sensitive nature of the data that will be collected, all participants will remain anonymous and no reporting of any information that could potentially identify the subjects will be mentioned in the study.

To further mitigate any potential harm to participants, a confidential wellness check will be conducted 48-72 hours after the completion of the interview. You will be contacted by the primary researcher via your preferred method of communication, and if helpful you will be referred to trained counselors or other resources for additional support.

The rest of this form has more information to help you decide whether to participate: Please read this consent form to learn more about the study. If you decide to participate, you will be asked to sign at the end of this form. If you have any questions about participating in the study or about the information in the form, please contact Lydia Garrett-Metz at lgarrettmetz@tulane.edu or at 516-319-3889.

About this consent form

This form tells you about the study and has information to help you decide whether you want to participate. The study site investigator will also talk with you about whether you are eligible to participate and about what participation involves.

If you are interested in participating in the study, please read this form carefully. It is important for you to consider what the study involves, including what will be required of you and the risks, and possible benefits, of participation. You may want to discuss the information in the form with a family member or friend. The form tells you the names of people you can contact if you have questions.

If you decide to participate, you will be asked to sign your name at the end of this form to show that you understand the information provided to you and that you agree to be in the study. You will receive a copy of your signed form to keep.

What is the research study and why is it being done?

You may be eligible to participate in this study because you may fit the criteria of the study population, as either an undocumented Latina migrant in the Greater New Orleans area or a service provider of mental healthcare in this area.

The purpose of this study is to understand the behavioral health needs of undocumented Latina migrants in the U.S., from the perspective of the women themselves, as well as those who provide services. The study is examining how the mental healthcare system works and doesn't work for this population, and what can be done to improve access and care.

The study is being carried out at Tulane University and at other sites in the Greater New Orleans area, such as Program Believe. Across all sites, about 24 to 28 individuals will participate in the study. The Tulane University Social/Behavioral Institutional Review Board is an ethics board that is responsible for overseeing the study and for making sure that participants' rights and well-being are protected.

Who is paying for the study?

Tulane University is providing the support for this study, in coordination with the study site investigator. Tulane will not be providing any funding directly to the study site investigator for the purpose of this study.

What will you do if you participate in the study?

If you agree to be in the study, we will ask you to read and sign this form. After you sign this form, you will participate in the procedures described below. Your participation in the study will last about eight months in total, though you are only expected to participate in *one* interview during this time period.

Research Procedures: If you are eligible for the study, you will take part in the following procedures:

- Experimental Procedures: Data for the interviews will be collected by the primary researcher and will be used to illustrate the personal experiences of undocumented women dealing with mental illness and the American mental healthcare system. Interviews will be conducted in-person or via Zoom, based on your preference, and are flexible in length – though the desired time is about 30 to 60 minutes. Information discussed may not be reviewed or analyzed in real-time, and thus participants should seek immediate care if they feel like they might harm themselves or otherwise need immediate help. Interviews will be video or audio recorded, transcribed using a secure data software, and all recordings will be destroyed following the completion of the study. If you wish to participate in an interview but would *not* like to be recorded, that is okay too. You can opt out of recording (video and/or audio) at any time – the researcher will be happy to accommodate this desire.

Follow-Up Procedures: After you have finished the research procedures, we would like to check in with you to see how you are doing. You will participate in the following follow-up procedures:

- A confidential wellness check will be conducted 48-72 hours after the completion of the interview. You will be contacted by the primary researcher via your preferred method of communication, and you will be referred to trained counselors or other resources for additional support if you so need or desire. No information from your wellness check will be recorded, transcribed, or otherwise retained.

If you take part in this study, how will we protect your privacy?

In this study, identifiable information about you will be collected. The identifiable information may be collected from study procedures, including interviews. We will do our best to make sure that the information gathered for this study that identifies you is kept private. However, we cannot guarantee total privacy.

If we think that you intend to harm yourself or others, we may be required or permitted by law to notify the appropriate people with this information. If we learn about current or ongoing child or elder abuse or neglect, we may be required or permitted by law to report this information to authorities.

In order to help make sure that only the necessary people or groups see, use, and share your identifiable information, the researcher will keep this information in a secure database only accessible by the study site team. Also, before we share your identifiable information with other people or groups for the study, your name will be removed from the information and the information that is shared will be labeled with a code instead of your name. In those cases, a key to the code connects your name to the information; we will keep the key to the code.

We may remove the identifiers from your information to create information that does not identify you. This information may be used or shared for research studies or other purposes without your permission.

What are the risks and possible discomforts from being in the study?

Your participation in this study may expose you to the risks or discomforts described below. Some of the interview questions may make you uncomfortable or upset, and you do not have to answer any question that you do not wish to.

There is the potential for loss of confidentiality by participating in the study. Appropriate efforts will be made to protect the confidentiality of your identifiable information as described earlier in this form.

There may be other risks that are currently unknown.

What are the possible benefits from being in the study?

You will not receive any direct benefit from participating in the study. We hope that this study will provide a space for participants to voice their concerns and experiences about the mental healthcare system in the U.S. and the way that it serves, or fails to serve, undocumented Latina migrants. Furthermore, we hope that what we learn in this study will provide the policy recommendations that may contribute to efforts at change that will positively impact undocumented migrants. In addition, all participants will be provided a resource guide that draws on the extensive research in the study.

Will you be paid to take part in the study?

You will not be paid to be in this study.

Tulane, the study site, or the study site investigator may use information from the study to develop a new product to be sold. These parties or others may benefit if this happens. There are no plans to pay you if information is used for this purpose.

What if new information about the study or the study procedures becomes available after you have given consent to participate?

Sometimes new information is learned about a study or about study procedures after the study has started. The study site investigator will tell you if new information is learned that could lead you to change your mind about participating in the study.

What are your other options besides study participation?

You have the option to not participate in the study. If you do not want to participate in the study, or if you drop out of the study, you will not lose any of your regular benefits and you can still get care if you need it.

If you start participating in the study, can you stop later?

If you participate in the study and want to stop, you can do so at any time. You will not lose any of your regular benefits, and you can still get care if you need it. You should tell the study site investigator or another member of the study site team if you want to stop participating.

Is it possible that you will have to stop participating in the study even if you want to complete it?

Even if you want to complete the study, it is possible that the study site investigator will stop your participation before you finish all of the study procedures. It is sometimes necessary to take study participants out of the study without their permission. For example, this may happen if you are no longer eligible to participate in the study.

What happens at the end of the study or if you leave the study early?

At the end of the study, the study site investigator will produce a formal report of the data collected. This report may include information (scrubbed of personal identifiers) shared in your interview, in addition to other research done by the study team.

If you decide to leave the study early, a formal report of the data collected will still be produced. This report will not include information shared in your interview.

What is done with the results from the study?

The results of the study may be presented at meetings or in publications. You will not be identified in any summary, presentation, or publication of the study results without your specific permission.

There are no plans to provide you with information about the results of the study, the results of your individual participation in the study, or the results of any research that is not part of the study that may be done as provided in this form, even if those results may be relevant to your health.

What if you have questions or concerns about the study?

Take as much time as you like before you make a decision to participate in this study. If you have any questions or concerns about the study, whether before or after signing this form, you can call any of the people or offices listed below. You can call about any matter

having to do with the study, including complaints or questions about your rights as a study participant.

Study Site Investigator (Researcher): Lydia Garrett-Metz

- Phone: 516-319-3889
- Email: lgarrettmetz@tulane.edu

Faculty Advisor**:** Eva Silvestre

- Phone: 504-988-7293
- Email: esilvest@tulane.edu

If you want to speak with someone who is not directly involved in the study, contact the Tulane University Human Research Protection Office.

- Phone: 504-988-2665
- Email: irbmain@tulane.edu

Consent

Statement of Study Site Investigator or Person Obtaining Consent

- I have explained the study to the study participant.
- I have answered the participant's questions about the study to the best of my ability.

_____ _____

Signature of Study Site Investigator or Person Obtaining Consent Date

_____

Print Name

Statement of Person Giving Consent

- I have read this consent form, or it has been read to me.
- This study has been explained to me, including risks and possible benefits (if any) and other options besides study participation.
- I have had the opportunity to ask questions.
- I understand the information that has been provided to me.
- I have had enough time to think about participation in the study.

Initial here if you consent to the following statement. *Reminder: You are not required to consent to be eligible for participation in this study.*

I consent to being audio and/or video recorded during my interview. _____

Signature of Participant:

I give my consent to participate in the research described in this form.

Signature of Study Participant	Date	Time

Print Name

APPENDIX E: INFORMED CONSENT FORM – SPANISH

Tulane University Human Research Protection Office
Social/Behavioral IRB
Consent Form for Participation in a Research Study
Wall After Wall: Mental Healthcare for Undocumented Latina Migrants

Formulario de Consentimiento de Investigación

Study Title: Wall after Wall: Mental Healthcare for Undocumented Latina Migrants
Study Site: Tulane University
Study Site Investigator (Researcher): Lydia Garrett-Metz
Faculty Advisor: Eva Silvestre

El Resumen

La investigación no es un tratamiento:

Usted puede ser elegible para participar en un estudio de investigación. La investigación no es un tratamiento. El propósito de esta investigación es entender las necesidades de salud conductuales decir, el bienestar mental, social y emocional de las migrantes latinas indocumentadas en los Estados Unidos, desde la perspectiva de las mujeres mismas, así como de las que proveen servicios. El estudio está examinando cómo funciona y no funciona el sistema de salud mental para esta población, y qué se puede hacer para mejorar el acceso y la atención.

Si participa en la investigación depende de usted:

Es su elección (1) saber si reúne los requisitos para participar en el estudio y, en caso afirmativo, (2) participar. Si decide participar, puede dejar de hacerlo en cualquier momento. Si usted no participa, o si participa pero se detiene más tarde, no perderá ninguno de sus beneficios regulares y aún puede obtener atención si la necesita.

Si usted participa, implicará lo siguiente:

La participación en este estudio implica una entrevista de 30-60 minutos para discutir sus experiencias y conocimientos sobre este tema. Las entrevistas se realizarán en persona o a través de Zoom y se grabarán en audio y/o vídeo, con su consentimiento. Las entrevistas no tienen que ser grabadas; también puede participar en una entrevista sin grabar.

La participación conlleva algunos riesgos que debe considerar cuidadosamente:

La participación en este estudio puede exponerle a estos riesgos o molestias comunes: Algunos temas que podrían ser de naturaleza delicada pueden aparecer durante las entrevistas.

Se considera que los riesgos de este estudio son mínimos; a pesar de la naturaleza delicada de los datos que se recopilarán, todos los participantes permanecerán anónimos y no se mencionará en el estudio ninguna información que pueda identificar a los sujetos.

Para mitigar aún más cualquier daño potencial a los participantes, se llevará a cabo una comprobación confidencial de bienestar 48-72 horas después de la finalización de la

entrevista. Usted será contactado por el investigador primario a través de su método preferido de comunicación, y si es útil será referido a consejeros capacitados u otros recursos para apoyo adicional.

El resto de este formulario tiene más información para ayudarle a decidir si desea participar:
Lea este formulario de consentimiento para obtener más información sobre el estudio. Si decide participar, se le pedirá que firme al final de este formulario. Si tiene alguna pregunta acerca de la participación en el estudio o acerca de la información contenida en el formulario, póngase en contacto con Lydia Garrett-Metz en lgarrettmetz@tulane.edu o al 516-319-3889.

Acerca de este formulario de consentimiento

Este formulario le informa sobre el estudio y contiene información para ayudarle a decidir si desea participar. El investigador del centro del estudio también hablará con usted sobre si es elegible para participar y sobre lo que implica la participación.

Si usted está interesado en participar en el estudio, por favor lea este formulario cuidadosamente. Es importante que usted considere lo que implica el estudio, incluyendo lo que se le exigirá y los riesgos y posibles beneficios de la participación. Usted puede querer discutir la información en el formulario con un miembro de la familia o amigo. El formulario le indica los nombres de las personas con las que puede ponerse en contacto si tiene alguna pregunta.

Si decide participar, se le pedirá que firme su nombre al final de este formulario para demostrar que comprende la información que se le ha proporcionado y que acepta participar en el estudio. Usted recibirá una copia de su formulario firmado para guardar.

¿Qué es el estudio de investigación y por qué se hace?

Usted puede ser elegible para participar en este estudio porque puede ajustarse a los criterios de la población del estudio, ya sea como una migrante latina indocumentada en el área metropolitana de Nueva Orleans o como proveedor de servicios de atención médica mental en esta área.

El propósito de este estudio es entender las necesidades de salud conductual de las migrantes latinas indocumentadas en los Estados Unidos, desde la perspectiva de las mujeres mismas, así como de las que proveen servicios. El estudio está examinando cómo funciona y no funciona el sistema de salud mental para esta población, y qué se puede hacer para mejorar el acceso y la atención.

El estudio se está llevando a cabo en la Universidad de Tulane y en otros sitios del área metropolitana de Nueva Orleans, como el Programa Believe. En todos los centros, entre 24 y 28 personas participarán en el estudio, y entre 10 y 12 de ellos serán del Programa CREE. Lydia Garrett-Metz es la investigadora del centro del estudio a cargo del estudio en la Universidad de Tulane y Program Believe. La Junta de Revisión Institucional Social/de Comportamiento de la Universidad de Tulane es una junta de ética que es

responsable de supervisar el estudio en Program Believe y de asegurarse de que los derechos y el bienestar de los participantes estén protegidos.

¿Quién paga el estudio?

La Universidad de Tulane proporciona el apoyo para este estudio, en coordinación con el investigador del centro del estudio. Tulane no proporcionará ningún tipo de financiación directamente al investigador del centro del estudio para estos fines de este estudio.

¿Qué hará si participa en el estudio?

Si acepta participar en el estudio, le pediremos que lea y firme este formulario. Después de firmar este formulario, participará en los procedimientos que se describen a continuación. Su participación en el estudio durará unos ocho meses en total, aunque sólo se espera que participe en una entrevista durante este período.

Procedimientos de investigación: Si es elegible para el estudio, participará en los siguientes procedimientos:

- Procedimientos Experimentales: Los datos para las entrevistas serán recogidos por el investigador primario y serán utilizados para ilustrar las experiencias personales de mujeres indocumentadas que se enfrentan a enfermedades mentales y al sistema de salud mental estadounidense. Las entrevistas se llevarán a cabo en persona o a través de Zoom, según sus preferencias, y son flexibles en su duración, aunque el tiempo deseado es de unos 30 a 60 minutos. Es posible que la información discutida no se revise o analice en tiempo real, por lo que los participantes deben buscar atención inmediata si sienten que podrían hacerse daño o necesitar ayuda inmediata. Las entrevistas se grabarán en vídeo o audio, se transcribirán utilizando un software de datos seguro, y todas las grabaciones se destruirán tras la finalización del estudio. Si desea participar en una entrevista pero no desea que se le grabe, también está bien. Usted puede optar por no grabar (video y/o audio) en cualquier momento – el investigador estará encantado de acomodar este deseo.

Procedimientos de seguimiento: Una vez que haya terminado los procedimientos de investigación, nos gustaría comprobar con usted cómo lo está haciendo. Participará en los siguientes procedimientos de seguimiento:

- Se llevará a cabo una comprobación de estado confidencial 48-72 horas después de la finalización de la entrevista. Usted será contactado por el investigador primario a través de su método preferido de comunicación, y usted será referido a consejeros entrenados u otros recursos para apoyo adicional si usted así lo necesita o desea. No se registrará, transcribirá ni conservará ninguna información de su chequeo y analisis de bienestar.

Si participa en este estudio, ¿cómo protegeremos su privacidad?

En este estudio, se recopiló información identificable sobre usted. La información identificable puede ser recolectada de los procedimientos del estudio, incluyendo entrevistas. Haremos todo lo posible para asegurarnos de que la información recopilada para este estudio que lo identifica se mantenga privada. Sin embargo, no podemos garantizar una privacidad total.

Si pensamos que usted tiene la intención de hacerse daño a sí mismo o a otros, podemos ser requeridos o permitidos por la ley para notificar a las personas apropiadas con esta información. Si conocemos o aprendemos sobre el abuso o negligencia actual o en curso de niños o ancianos, podemos ser requeridos o permitidos por la ley para reportar esta información a las autoridades.

Para ayudar a asegurarse de que sólo las personas o grupos necesarios vean, utilicen y compartan su información identificable, el investigador mantendrá esta información en una base de datos segura a la que sólo pueda acceder el equipo del centro del estudio. Además, antes de compartir su información identificable con otras personas o grupos para el estudio, su nombre será removido de la información y la información compartida será etiquetada con un código en lugar de su nombre. En esos casos, una clave del código conecta su nombre con la información; guardaremos la clave del código..

Podemos eliminar los identificadores de su información para crear información que no lo identifique. Esta información puede ser utilizada o compartida para estudios de investigación u otros propósitos sin su permiso.

¿Cuáles son los riesgos y posibles molestias de participar en el estudio?

Su participación en este estudio puede exponerle a los riesgos o molestias que se describen a continuación. Algunas de las preguntas de la entrevista pueden hacerle incómodo o molesto, y usted no tiene que contestar ninguna pregunta que usted no desee.

Existe la posibilidad de que se pierda la confidencialidad al participar en el estudio. Se harán los esfuerzos apropiados para proteger la confidencialidad de su información identificable como se describe anteriormente en este formulario.

Es posible que existan otros riesgos que actualmente se desconocen.

¿Cuáles son los posibles beneficios de participar en el estudio?

No recibirá ningún beneficio directo por participar en el estudio. Esperamos que este estudio proporcione un espacio para que los participantes expresen sus preocupaciones y experiencias sobre el sistema de salud mental en los Estados Unidos y la manera en que sirve, o no sirve, a las inmigrantes latinas indocumentadas. Además, esperamos que lo que aprendamos en este estudio proporcione las recomendaciones de política que pueden contribuir a los esfuerzos de cambio que impactarán positivamente a los migrantes indocumentados.

Se proporcionará a todos los participantes una guía de recursos que se basa en la extensa investigación del estudio.

¿Se le pagará por participar en el estudio?

No se le pagará por participar en este estudio.

Tulane, el centro del estudio o el investigador del centro del estudio pueden utilizar la información del estudio para desarrollar un nuevo producto que se podra vender. Estas partes u otras pueden beneficiarse si esto sucede. No hay planes de pagarle si la información se usa para este propósito.

¿Qué ocurre si se dispone de nueva información sobre el estudio o los procedimientos del estudio después de haber dado su consentimiento para participar?

A veces se aprende nueva información sobre un estudio o sobre los procedimientos del estudio una vez iniciado el estudio. El investigador a cargo del estudio le indicará si considera información nueva que pueda llevarle a cambiar de opinión sobre la participación en el estudio.

¿Cuáles son sus otras opciones además de la participación en el estudio?

Tiene la opción de no participar en el estudio. Si no desea participar en el estudio, o si abandona el estudio, no perderá ninguno de sus beneficios regulares y podrá recibir atención si la necesita.

Si comienza a participar en el estudio, ¿puede dejar de participar más tarde?

Si participa en el estudio y desea detenerlo, puede hacerlo en cualquier momento. Usted no perderá ninguno de sus beneficios regulares, y aun así puede recibir atención si la necesita. Debe informar al investigador a cargo del estudio o a otro miembro del equipo del centro del estudio si desea dejar de participar.

¿Es posible que tenga que dejar de participar en el estudio aunque desee completarlo?

Incluso si desea finalizar el estudio, es posible que el investigador del centro del estudio suspenda su participación antes de que finalicen todos los procedimientos del estudio. A veces es necesario sacar a los participantes del estudio sin su permiso. Por ejemplo, esto puede suceder si ya no es elegible para participar en el estudio.

¿Qué sucede al final del estudio o si abandona el estudio antes de tiempo?

Al final del estudio, el investigador del centro del estudio elaborará un informe formal de los datos recopilados. Este informe puede incluir información (depurada de identificadores personales) compartida en su entrevista, además de otras investigaciones realizadas por el equipo del estudio.

Si decide abandonar el estudio antes de tiempo, todavía se elaborará un informe formal de los datos recopilados. Este informe no incluirá información compartida en su entrevista.

¿Qué se hace con los resultados del estudio?

Los resultados del estudio pueden presentarse en reuniones o en publicaciones. Usted no será identificado en ningún resumen, presentación o publicación de los resultados del estudio sin su permiso específico.

No hay planes para proporcionarle información sobre los resultados del estudio, los resultados de su participación individual en el estudio, o los resultados de cualquier investigación que no forme parte del estudio que se pueda realizar como se indica en este formulario, incluso si esos resultados pueden ser relevantes para su salud.

¿Qué pasa si tiene preguntas o inquietudes sobre el estudio?

Tómese todo el tiempo que desee antes de tomar la decisión de participar en este estudio. Si tiene alguna pregunta o inquietud sobre el estudio, ya sea antes o después de firmar este formulario, puede llamar a cualquiera de las personas u oficinas que se enumeran a continuación. Usted puede llamar sobre cualquier asunto que tenga que ver con el estudio, incluyendo quejas o preguntas sobre sus derechos como participante del estudio.

Investigadora del centro del estudio (Investigadora): Lydia Garrett-Metz

- Teléfono: 516-319-3889
- Correo electrónico: lgarrettmetz@tulane.edu

Asesora de Facultad: Eva Silvestre

- Teléfono: 504-988-7293
- Correo electrónico: esilvest@tulane.edu

Si desea hablar con alguien que no está directamente involucrado en el estudio, póngase en contacto con la Oficina de Protección de Investigación Humana de la Universidad de Tulane.

- Teléfono: 504-988-2665
- Correo electrónico: irbmain@tulane.edu

Formulario de Consentimiento

Declaración del Investigador del Centro del Estudio o de la Persona que Obtiene el Consentimiento

- He explicado el estudio al participante.
- He respondido a las preguntas del participante sobre el estudio lo mejor que puedo.

_____ _____

Firma del Investigador o de la Persona que Obtiene el Consentimiento Fecha

_____

El Nombre Completo Con Letra De Molde

Declaración de la Persona que Da su Consentimiento

- He leído este formulario de consentimiento o se me ha leído.
- Se me ha explicado este estudio, incluidos los riesgos y los posibles beneficios (si los hubiera) y otras opciones además de la participación en el estudio.
- He tenido la oportunidad de hacer preguntas.
- Entiendo la información que se me ha proporcionado.
- He tenido tiempo suficiente para pensar en participar en el estudio.

Si acepta la siguiente declaración, escriba sus iniciales aquí. *Recordatorio: No es necesario que dé su consentimiento para ser elegible para participar en este estudio.*

Acepto que se grabe un vídeo durante mi entrevista. _____

Firma del Participante:

Doy mi consentimiento para participar en la investigación descrita en este formulario

_____ _____ _____

Firma del Participante del Estudio Fecha Tiempo

_____

El Nombre Completo Con Letra De Molde

APPENDIX F: CODE BOOK

CODE	DEFINITION
Systems Level Issues	
Border/Migration Policies	Participant describes the impact of U.S. border and immigration policies on their clients or organizations; participant describes the impact of U.S. border and immigration policies on themselves, their families, or their larger communities
Need for Systems Change	Participants speaks to the need for systems to change from the top down; participant explains the importance of focusing on undercurrents instead of solely surface issues to provide holistic interventions for the mental health of the study population
Insurance	Participant describes how their client or their organization has been impacted by (lack of coverage from) the U.S. health insurance system; participant describes how their mental health or their ability to access mental health services have been impacted by (lack of coverage from) the U.S. health insurance system
Language	Participant describes how their client or their organization has been impacted by disparities in language access; participant describes challenges receiving or accessing mental health care because of disparities in language access; participant speaks to the importance of space, resources, and community being made accessible in languages other than English as a human right, not just a service
Education	Participant describes how their client or their organization has been impacted by disparities or discrimination in the U.S. education system; participant describes challenges interacting with the U.S. education system (that impacted their mental health); participant explains the issues caused in a migrant's experience in the U.S. because of lack of knowledge
Geographic Care Disparities	Participant describes disparities in access to or quality of mental healthcare/services to undocumented migrants based on geography (internationally and domestically)
Limited/Inequitable Opportunities	Participant describes how their client has been impacted by the lack of opportunities provided to them in the U.S.; participant expresses how they are given less opportunities in the U.S. because of their immigration status; participant delineates between opportunities provided to U.S. citizens and the undocumented
Cultural Level Issues	
Cultural Issue - Colonizer Mentality	Participant describes commodification of migrant trauma or transactional behavior/language/communication; participant explains their experience with white supremacist culture or the concept of the American Dream; participant references the dance between being the colonized and the colonizer in modern day in this type of work
Cultural Issue - Cultural Lumping	Participant describes being "lumped" into the "Latino" or "Hispanic" population despite identifying as something deeper; participant describes their country of origin being thought of as identical to every other Spanish-speaking country (American culture whitewashing their differences); participant references white-washing of Hispanic/Latino culture in the U.S.
Centering Culture	Participant speaks to the importance of centering Hispanic/Latino culture in research or in service provision
Community	Participant speaks to the importance of fostering a sense of community among undocumented Latinos in the U.S.; participant references loneliness and/or mental health issues (i.e., depression) as a result of loss of community due to migration
Organizational Structure	
Funding and Financing	Participant explains how their organization is funded; participant explains how their organization's funding effects their work/outputs
Staff	Provider shares number of staff at their organization; provider describes staff in their organization or of other migrant-serving organizations in terms of their capabilities, training, educational and racial/ethnic backgrounds, time at the organization, language (s) spoken, etc.
Organizational Capacity	Provider describes the capacity of their organization or of other migrant-serving organizations to meet the needs of the service population
Referrals	Participant describes the referral process of their organization or speaks to the process used by other migrant-serving organizations; participant explains how they were referred to or found an organization
Provider Experiences	
Provider Methodology	Participant describes how they currently provide care to the service population or how they wish they could provide care to the service population; participant describes the approach they take to service provision or explains why they do so
Provider Lived Experience	Provider describes their own experience with migration, Hispanic/Latino culture, mental illness, mental healthcare access etc.; provider explains the importance of staff that understands and can relate to the multifaceted sociocultural and historical identities of the service population
Impact on Provider	Provider describes the toll working with the study population has taken on them or other members of their organization; provider describes the joy working with the study population has brought them or other members of their organization
Provider Self Care	Provider describes strategies for self-care (wishful or currently practiced) to mitigate the impacts of this field of work on their mental health and wellbeing
Existing Service Provision	
Existing Services - Social	Participant describes that their organization provides social/cultural services to clients or would like their organization to provide social/cultural services; participant describes receiving social/cultural services from an organization
Existing Services - Legal	Participant describes that their organization provides legal services to clients or would like their organization to provide legal services; participant describes receiving legal services from an organization
Existing Services - Health/Medical	Participant describes that their organization provides health/medical services to clients or would like their organization to provide health services; participant describes receiving health/medical services from an organization
Existing Services - Language	Participant describes that their organization offers language classes or interpretation services to clients or would like their organization to provide language services; participant describes receiving language services from an organization
Existing Services - Advocacy	Participant describes that their organization advocates on behalf of clients or would like their organization to do advocacy work; participant describes their experience with an organization's advocate(s)
Existing Services - Education	Participant describes that their organizations provides educational services to clients or would like their organization to provide educational services; participant describes receiving educational services from an organization
Provider/Client Relationships	
Compassion	Participant describes the ideal provider/client relationship as one that is underscored by compassion and nurturing; participant explains the importance of passionate and caring providers in this field
Client Autonomy	Participant describes the ideal provider/client relationship as one that promotes the autonomy of the client; participant shares the detriments of a patronizing approach to service provision or the necessity of helping clients find and honor their sense of self
Participant Demographics	Participant shares about their background, the background of their family, the background of their client(s), etc.
Client Experiences	
Stigma	Participant describes traumatic experiences faced by study population/clients due to stigma related to immigration status, lived experience, health concerns, etc.; participant describes their own traumatic experiences due to stigma related to immigration status, lived experience, health concerns, etc.
Violence/Abuse	Participant describes experiences faced by study population/clients relating to violence or abuse (physical/emotional, sexual, verbal); participant describes their own experiences relating to violence or abuse
Family Separation	Participant describes experiences faced by study population/clients relating to family separation; participant describes their own experiences relating to family separation
Mental Illness	Participant talks about their mental health or the mental health of their clients in a general sense; participant talks about their mental health or the mental health of their clients in specificity, including referencing specific diagnoses or cases of interest

Lack of Mobility	Participant describes experiences faced by study population/clients related to their inability to advance socioeconomically in society or physically transport themselves from place-to-place; participant describes their own experiences relating to their inability to advance socioeconomically in society or physically transport themselves from place-to-place
Racism/Colorism	Participant describes experiences of study population/clients encountering interpersonal and/or institutional racism and/or colorism; participant describes their own experiences encountering interpersonal and/or institutional racism and/or colorism
Criminalization	Participant describes study population/clients facing criminialization from U.S. institutions or individuals, despite no wrongdoing; participant describes being criminalized by U.S. institutions or individuals, despite no wrongdoing
Sickness/Ailment	Participant describes experiences faced by study population/clients relating to sickness/ailment; participant describes their own experiences relating to sickness/ailment
Poverty	Participant describes experiences faced by study population/clients relating to poverty; participant describes their own experiences relating to poverty
Pregnancy	Participant describes experiences faced by study population/clients relating to pregnancy (specifically teen pregnancy); participant describes their own experiences relating to pregnancy (specifically teen pregnancy)
Parent/Child Relationship	Participant describes the relationships between parent and child observed in the study population/client; participant describes their own parent/child relationship
Cultural Beliefs	
Sickness/Ailment	Participant describes their clients beliefs about sickness/ailment; participant describes their own beliefs about sickness/ailment; participant speaks to beliefs about sickness/ailment in the greater Hispanic/Latino cultural context
Avoidance	Participant describes their clients beliefs about avoidance of U.S. systems and institutions; participant describes their own beliefs about avoidance of U.S. systems and institutions; participant speaks to beliefs about sickness/ailment in the greater Hispanic/Latino cultural context
Family	Participant describes their clients beliefs about family and the role of family; participant describes their own beliefs about family and the role of family; participant speaks to beliefs about the role of family in the greater Hispanic/Latino cultural context
Suffering	Participant describes their clients beliefs about suffering; participant describes their own beliefs about suffering; participant speaks to beliefs about suffering in the greater Hispanic/Latino cultural context
Religion	Participant describes their clients religious beliefs; participant describes their own religious beliefs; participant speaks to religious beliefs in the greater Hispanic/Latino cultural context
Healing	Participant describes their clients beliefs about healing; participant describes their own beliefs about healing participant speaks to beliefs about healing in the greater Hispanic/Latino cultural context
Gender Roles	Participant describes their clients beliefs about patriarchy and femininity or male and female gender roles; participant describes their own beliefs about patriarchy and femininity or male and female gender roles; participant speaks to beliefs about patriarchy and femininity or male and female gender roles in the greater Hispanic/Latino cultural context